WINNIPEG
CONSULTATION & NEEDS ASSESSMENT

SAFER CONSUMPTION SPACES

"I FOUND THAT THE ONES [SERVICE PROVIDERS] THAT HAVE LIFE EXPERIENCE, THEY HAVE A LOT MORE EMPATHY, AND PEOPLE THEY ARE TALKING TO THEY DON'T FEEL JUDGED."

- PARTICIPANT, ON THE SUBJECT OF: HUMAN SERVICES, SUPPORT, OR HELPERS

ACKNOWLEDGEMENTS

This study took place on the ancestral lands of the Anishinaabeg, Cree, Oji-Cree, Dene, and Dakota peoples, and the homeland of the Métis nation, Treaty 1 territory. We approach this project in partnership and collaboration and with a commitment to reconciliation.

We are immensely grateful to the participants who shared their knowledge, expertise, and stories in this consultation. This consultation was guided by the **Safer Consumption Spaces Working Group** (see Appendix A), a voluntary collective of people from organizations who came together with a common interest in learning from people who use drugs about the spaces of everyday drug use, and the spaces they envision and value.

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THE RESEARCH/CONSULTATION TEAM:
Margaret Ormond, Shelley Marshall, Paula Migliardi, Chelsea Jalloh, Debbie Stewart, Aliya Jamal, Kirsten Bourque, Bobbi Hudon, JD Ormond, Sheila Soulsby, Laurel Cassels and Heather Ashdown

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Canadian Research Initiative in Substance Misuse

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***PARTICIPANT QUOTES ARE SHARED THROUGHOUT THIS REPORT IN QUOTATION MARKS.**

"AT MY PARENTS' HOUSE THEY MIGHT FIND OUT [THAT I USE]. LIKE PEOPLE HAVE BIG MOUTHS, AND IT WOULD JUST KILL THEM. THEY WOULD BE SO DISAPPOINTED AND I DON'T WANT TO HURT THEM. I DON'T NEED THEM CATCHING ME."

- PARTICIPANT, ON THE SUBJECT OF: STIGMA

EXECUTIVE SUMMARY

The spaces in which drugs are consumed have significant impacts on drug use practices and the conditions for drug-related harms and benefits. To inform appropriate policies, programs, and practices in Winnipeg, including supervised consumption services, we sought the wisdom of people with lived experience in navigating and reducing drug-related harms within the spaces of Winnipeg's inner-city.

STUDY OBJECTIVES

- To explore the relationships between spaces of drug consumption, drug use practices, and drug-related harms and benefits
- To assess the spatial needs and preferences of people who use drugs in order to inform harm reduction interventions in private, public, and professional/organizational spaces where people may come to consume drugs
- To inform current and emerging harm reduction services in Winnipeg that are acceptable, accessible, and appropriate for people who use drugs in the local context

Guided by the Safer Consumption Spaces Working Group, we developed and implemented a World Café methodology to consult with people who use drugs. In the summer of 2018, we gathered with three groups of people in three different inner-city locations. Thirty-eight participants shared their knowledge in these sessions, and these discussions were supplemented with a brief questionnaire. Preliminary findings from these consultations were validated at a feedback session with 16 other participants.

Additionally, formal and informal service providers and organizational representatives shared their perspectives on supervised consumption services in either a focus group or individual interviews.

Participants' needs for safe spaces extended far **beyond places for drug consumption**. Lack of safe spaces in which to sleep, eat, be high, meet with friends, have fun, and to access care and services were described. More than 50% of the participants had no permanent residence, and were prohibited or excluded from many public spaces in their neighbourhood. Large proportions of participants indicated that they would likely use recreational services, rapid access addiction medicine clinics, harm reduction supplies, and supervised consumption services if they were available, or more readily available.

HARMFUL CONTEXT AND ENVIRONMENTS

Some of the **key sources of harm** described by participants were not the drugs themselves but rather the social world that surrounds the

lives of people who use drugs. These included factors such as:

- Structural violence – drug prohibition, criminalization, imposed family separation
- Stigma related to drug use
- Pain, loss, trauma and discomfort
- Community violence
- Lack of social and material resources
- Drug expenditures and exchange
- Nature of the drug market and scene

CHARACTERISTICS OF DESIRABLE SAFE SPACES FOR DRUG USE

The following **10 characteristics of spaces were considered desirable and safety enhancing** by participants**,** regardless of the type of space (private residence, public space, or supervised consumption service).

- More than just a space to consume drugs/ accommodates other needs
- Human support, services, or helpers available
- Convenient and easy
- Familiar and promotes autonomy
- Calm and comforting
- Clean and materially resourced
- Private and low profile
- Away from children or places children congregate
- Safe and secure
- Rules, norms, and/or guidelines are respected

IMPLICATIONS FOR SUPERVISED CONSUMPTION SERVICES (SCS)

If SCS are being planned or developed in Winnipeg, the following recommendations arose from those consulted:

- Involve people who use the service in organizational and service delivery decision making;
- Provide a space that promotes social interaction, belonging, community, and/or an opportunity to become involved meaningfully through employment or volunteering;
- Involve people with drug use experience in service delivery;
- Attach SCS to a site that offers other services and resources, such as;
    - culture-based prevention and treatment programs
    - health and social services that are culturally safe, harm reduction grounded, and trauma-informed or healing-centred (housing, income, counselling, addictions, detox, harm reduction);
- Locate SCS in the inner-city, and offer the widest operating hours possible;
- Locate SCS away from where children congregate, and from law enforcement;
- Protect people from arrest for drug possession, and general discrimination for drug use
- Create a familiar, private space that provides people a sense of control, and facilitates people's drug preparation and consumption routines;
- Create a calm and comforting atmosphere by way of lighting, sound, furniture, and human relations;
- Keep the space clean and provide harm reduction supplies (whether someone is staying to consume or not), and safe needle disposal;
- Provide a post-consumption space for snacks, recreation, showers, storage, and a safe space to be high;
- Recognize the needs of parents who use drugs while upholding the value of separating children from drugs via flexible child minding at a location nearby, but not within;

- Provide safety and security from being bothered for drugs, getting jumped or robbed for drugs, and dealers' territorial issues;
- Be mindful of how prohibiting common drug use practices, such as assisted injection, drug splitting and sharing, will result in barriers to SCS access. These activities are not supported by current Health Canada regulations.

SERVICE PROVIDERS' PERSPECTIVES

Provider participants felt a great need for expanded services for people who use drugs in Winnipeg and across Manitoba, particularly services grounded in a culturally safe, harm reduction perspective. Participants wanted to see more public spaces that are safer for people to use drugs in, or simply to be in. Provider perspectives varied on the degree to which SCS in Winnipeg are a priority, but they supported the establishment of SCS within the continuum of harm reduction and substance use services, especially if people who use drugs would value and access the service.

Among the benefits of SCS, providers were attuned with the positive outcomes from SCS across the country. Benefits included: overdose reversal, access to harm reduction supplies, access to drug checking, and provision of a safe and secure space for drug use away from street violence and criminalization. SCS were seen as an opportunity to increase access to relevant services such as primary care, housing, nutrition, detox or addictions treatment.

Participants acknowledged there would be barriers to access and limitations to the reach of SCS in Winnipeg. Challenges included the location(s), potential concerns that SCS may attract law enforcement, and the regulations around SCS that prohibit some practices, such as assisted injection (for people who are unable to inject themselves). Further, providers were concerned about the lack of public and provincial government support for SCS.

Providers made the following recommendations for any program wishing to develop SCS in Winnipeg:

- Consult and longitudinally involve people who use drugs in design and operation
- Establish multiple locations in the inner-city
- Integrate with other health and social services
- Incorporate staff that reflect the clientele
- Consider a design that takes into account diversity in the types of drugs consumed
- Address stigma and community backlash

CONCLUDING REMARKS

This study captured perspectives on safety and harms of drug use as they relate to spaces in which drugs are consumed, with implications for SCS in inner-city Winnipeg.

The characteristics of desirable and safe spaces for drug consumption described by participants reflected the principles of harm reduction: pragmatic, non-judgemental, respect for autonomy, privacy, resources, meaningful involvement, and inclusion. Some of the desirable spatial characteristics described are key features of SCS (material supplies, access to resources, human support or helpers), while other desirable characteristics such as convenience, privacy, and autonomy, are more challenging for SCS to deliver. Still, many participants indicated that they would likely access SCS, provided services are developed according to the priorities and values of those who would use them.

Providers were supportive of SCS, but realistic about the challenges for development and implementation in the local context. Still, providers were supportive of efforts to establish SCS if this is a service that people who use drugs would value and access.

"I USUALLY DO [DRUGS] BY MYSELF. I DON'T USE WITH ANYBODY. I'M TOO CHEAP WITH THIS STUFF, EVERYBODY'S TOO CHEAP... I STILL FEEL LONELY, LIKE I WOULDN'T MIND THE COMPANY, BUT PEOPLE ARE TOO CHEAP."

- PARTICIPANT, ON THE SUBJECT OF: STRUCTURAL VIOLENCE: DRUG PROHIBITION, CRIMINALIZATION, IMPOSED FAMILY SEPARATION, AND GENERAL INTERFERENCE

INTRODUCTION AND BACKGROUND

The spaces in which drugs are consumed have significant impacts on drug use practices and the conditions for drug-related harms and benefits. While there is local interest to explore the need for supervised consumption services (also called safe injection sites), drug use usually occurs in private and public spaces, and little is known about the spatial needs of people who use drugs.

Supervised consumption services (SCS) provide clean and decriminalized environments in which people can use illegal drugs under the supervision of a health care professional, a trained allied service provider, or a peer (i.e., person who formerly or currently uses illegal drugs), without the risk of arrest for drug possession (BC Ministry of Health and BC Centre on Substance Use, 2017). In response to the opioid crisis, in 2017, the Federal Government lifted some of the requirements for safer injection facilities. With these changes, new models and approaches to SCS are being pursued. Across the country, proposals and feasibility studies for mobile, women's only, and hospital-based SCS have emerged. A summary of the evidence regarding SCS in Canada is provided in Appendix C.

To inform appropriate policies, programs and practices in Winnipeg, we sought the wisdom of people with lived experience in navigating and reducing drug-related harms within many local environments. The safety considerations and harms addressed in this project were defined by people who use drugs. This consultation sought to gather experiential knowledge on the relationship between place, space, and drug use practices in order to learn how organizations can support safety in all spaces where drugs are consumed.

STUDY OBJECTIVES

- To explore the relationship between spaces of drug consumption, drug use practices, and drug-related harms and benefits.
- To assess the spatial needs and preferences of people who use drugs in order to inform harm reduction interventions in private, public, and professional spaces where people may consume drugs.
- To inform current and emerging harm reduction services in Winnipeg that are acceptable, accessible, and appropriate for people who use drugs in the local context.

THE SETTING/PLACE

For our purposes, the setting/place refers to the urban context and neighbourhood(s), in which this consultation took place. Winnipeg, Manitoba has a census metropolitan population of 825,713 people (Statistics Canada, 2018) with the largest

Indigenous population (92,810) of all urban centres in Canada (Statistics Canada, 2016). This study took place in inner-city Winnipeg, in the neighbourhoods of Downtown and Point Douglas/North End. Point Douglas and Downtown have significantly higher proportions of Indigenous residents than Winnipeg on average. There is strong community leadership and engagement specifically by Indigenous organizations and services in these neighbourhoods.

The average life expectancy is 10 years less in Winnipeg's racialized neighbourhoods with the lowest median household income (Point Douglas and Downtown), compared to Winnipeg neighbourhoods with the highest household income (City of Winnipeg, 2015). Settler colonialism, in-migration, suburbanization, and de-industrialization are key systems that have shaped the spatially concentrated, racialized poverty of Winnipeg's inner-city (Silver, 2015).

Housing and homelessness are significant concerns in Winnipeg. Among the 1500 people experiencing homelessness who were surveyed on April 17, 2018 as part of the *Winnipeg Street Census*, 33.3% identified as women, 18.6% identified as part of the lesbian, gay, transgender, two-spirited, queer (LGBT2SQ) community, 24% were youth, and 80.2% identified as Indigenous (Winnipeg Street Census, 2018). Poverty, homelessness, and street involvement are visible and racially stratified in these neighbourhoods, and access to resources and opportunities are systematically and historically unequally organized as a result of the ongoing colonial project (Comack, Deane, Morrissette & Silver, 2013).

Imposed family separation is extremely high in this setting, with 4.87% of children in Winnipeg removed from their families and place in care of other adults (Peg!, 2018). These rates are approximately double in Point Douglas (10.4%) and Downtown (8.3%). Today, Manitoba has some of the highest rates of children in state custody in the world, and roughly 90% of those children are Indigenous (Brownell et al., 2015; Gough, Trocmé, Brown, Knoke, & Blackstock, 2005; Milward, 2016). Unstably housed people who were interviewed for the Winnipeg Street Health Report (Gessler, Maes, & Skelton, 2011) reported significant contact with health and social services. Forty-three per cent of respondents (300) had been in the care of child welfare as a child or youth. Forty-five per cent had spent at least one night at a hospital in the past year, and 39% had been hospitalized for a mental health issue in their lifetime.

Winnipeg's drug use landscape is rapidly shifting with the emergence of bootleg fentanyl analogues increasing fatal and non-fatal opioid overdose (MHSAL, 2018), growing prevalence in the use of crystal methamphetamine (MHSAL, 2018), and a 4-fold increase in the demand for sterile injection drug use supplies since 2013 (Ross, 2017).

Manitoba does not have a provincial harm reduction supply distribution program. Although there are several needle distribution sites in Winnipeg, the funding that supports them is insufficient to meet the demand (Ross, 2017). Other types of harm reduction services, such as supervised consumption services, peer-run harm reduction organizations, managed alcohol programs, and rapid access to opioid replacement therapy, did not exist in Winnipeg at the time of this research.

This study explored the micro-environments (spaces) in which drugs are consumed in the setting of inner-city Winnipeg. These spaces included private residences, vehicles, parties, bars, hotels, public washrooms, or outdoor spaces, and they generally embodied many of the social characteristics of place and context (Tempalski & McQuie, 2009; Williams, 2016). This consultation focused specifically on the immediate spaces of drug consumption, which likely obscured the impacts of larger systems of power that shape the lives of people who use drugs.

CONSULTATIONS WITH PEOPLE WHO USE DRUGS

METHODOLOGY

Project approval was received by the Education/Nursing Research Ethics Board, University of Manitoba, and the Winnipeg Regional Health Authority Research Access and Review Committee.

We used community-based, participatory, and action-oriented approach to develop the research questions, method of exploration, validation, and translation of findings (Community Research Canada, 2018). Guided by the Safer Consumption Spaces Working Group (Appendix A), we developed and implemented a qualitative consultation with people who use drugs. Working Group members came from Indigenous and non-Indigenous organizations, and included people who use(d) drugs, and people who inform policies, programs, and practices that impact people who use drugs. The inclusion of multiple perspectives contributed to a more thorough perspective on the context surrounding inner-city drug use, and a safe and inclusive method for consulting people who use drugs.

To stimulate group dialogue we adopted a World Café (WC) methodology (Brown, Isaacs & the World Café Community, 2005) to discuss what safe/r drug use spaces and places look like in Winnipeg, which proved an effective method to learn from the knowledge and experiences of the participants. Contrary to a more conventional focus group, in which all individuals participate in one conversation, the WC involved a series of table stations, each with its own facilitator and note taker. During a session, participants were divided up into smaller groups (~4-6) that rotated through the four table stations (~12 minutes per station); each station provided an opportunity for participants to discuss considerations related to drug use in a particular space (outdoors, public washrooms, private residences, and supervised consumption services). A number of community members were hired to co-facilitate the sessions.

Strengths of the World Café method included:

- The WC began with a shared meal. Not only did this contribute towards the informal, conversational, and "café-like" environment a WC aims to achieve (Brown & Isaacs, 2005), especially when engaging with participants who may experience challenges such as food insecurity, this shared meal in a welcoming environment began to foster a collective group dynamic, in addition to addressing a practical need.
- The WC prioritizes collective and community-based knowledge (Brown, Isaacs & the World Café Community 2005; Sheridan,

"YEAH I'VE OVERDOSED ALONE AT HOME. WHAT COULD I DO? NOTHING. WELL SOMEBODY HAD TO HAVE FOUND ME - I'M STILL HERE. I ALWAYS ASK PEOPLE TO COME CHECK IN ON ME. I'LL SAY I'M GOING TO GO DO MY THING AND IF I DON'T COME OUT WITHIN A HALF HOUR OR SO, THEN COME KNOCK ON THE DOOR."

- PARTICIPANT, ON THE SUBJECT OF: USING ALONE AND RISK OF OVERDOSE

Adams-Eaton, Trimble, Renton, & Bertotti, 2010). Contrary to other consultation methods which may privilege "professional" or "scientific" knowledge, WC aims to provide a forum to celebrate emergent community wisdom (Aldred, 2011; Sheridan et al., 2010). A WC approach does not require participant consensus; rather, it can be an opportunity to explore diverse perspectives about complex or challenging topics (Johnson et al., 2018).

- A WC approach aims to challenge the disparate power dynamic between "researchers" and "participants" by privileging community knowledge over professional knowledge (Sheridan et al., 2010). Participants drove the conversations about the particular topics, and collectively identified the considerations of highest importance.
- Particularly when discussing potentially sensitive or stigmatized behaviour such as drug use, the WC method using smaller table groups helped to facilitate participation. Participants may have felt more comfortable sharing their insights in a group of 4 rather than in front of the whole group. Furthermore, during a WC, the table facilitator asked probing questions to the small group to help further develop ideas and invite participation.
- WC table facilitators were purposefully selected due to their expertise working with people who use drugs and/or their own lived experience. This purposeful selection of "non-academic" discussion facilitators contributed to the creation of a supportive, non-judgemental dynamic conducive to dialogue. In addition, facilitators demonstrated insightful skills in asking relevant probing questions to explore themes raised in discussion.
- Rotating table stations every ~12 minutes helped to break up the consultation and, in some cases, helped to facilitate prolonged participant engagement.

During the summer of 2018, we gathered with three groups of people in three different inner-city area locations – Sunshine House (Downtown Centennial), Merchant's Corner (North End), and Crossways in Common (West Broadway). Each WC session had different participant eligibility criteria in order to draw from different experiences of drug use. The first session was held for people who use crystal meth by any route, the second for people at risk of opioid overdose, the third for people who inject drugs.

Participants were recruited through the distribution of a handbill and word-of-mouth at locations where people who use drugs often meet or receive service. This approach included recruitment done by some of the members of the SCS Working Group or other key community partners, but mostly through members of the research team and harm reduction service providers (Street Connections, Nine Circles, Brother's Pharmacy, and Sunshine House).

Experiences of pain, trauma, loss, and situational crisis among participants were significant. Ensuring participant safety and comfort at the WC were paramount considerations. Screening and welcoming participants into the group sessions needed to occur efficiently as up to 20 participants were welcomed in and oriented to the study in a short period of time. As people arrived, prior to beginning the WC small group discussions, research staff completed the demographic questionnaires individually with participants, providing an opportunity to check in with each potential participant and assess their ability to provide informed consent. The completion of individual demographic questionnaires, and check in with each participant, was an important step as the consent process (which was also explained to the group collectively). Each participant received a consent form to review; the consent form was read aloud and reviewed by a member of the research team, and participants were provided an opportunity to ask questions. Following the group review, each participant submitted a signed consent form

before the WC discussions began. Participants were each provided a $20 gift card and two bus tokens honoraria.

For all sessions, recruitment was accomplished through the distribution of handbills/invitations from harm reduction service organizations, direct street outreach, and invitations through existing social networks of people who use drugs (specifically the MANDU network). Our first attempt to recruit did not render the expected number of participants to the WC session – while approximately 100 handbills were distributed, and over 20 people phoned to confirm their attendance, only 6 participants showed up. The second session was highly successful in attracting many individuals (19). For this session, no pre-registration by phone was required and the location of the second WC (Merchant's Corner) was nearby to a popular pharmacy where people access harm reduction services. For the third WC, we distributed handbills through similar methods to the first two sessions. While a few participants showed up to participate, it was the last-minute recruitment directly before the WC through outreach in the neighborhood that resulted in a significant number of additional participants (13). A few interested participants expressed that they could not attend the third WC as there were not options in the location (Crossways in Common) for them to safely leave their personal possessions (e.g., shopping carts, bicycles, or bed rolls). At least one person who had registered declined participation alleging possible relapse into drug use, something this person was struggling to stay away from as condition for getting her children back. A total of 38 participants shared their knowledge throughout these three WC sessions.

In order to verify emergent findings, in fall 2018, preliminary findings from the three WC sessions were shared with 16 people who use drugs in a knowledge translation session to inform and validate interpretation, and to provide an opportunity for participants to offer additional content or contextual information. With one exception, the participants who attended the knowledge translation session did not participate in the WC. However, preliminary findings were found to be consistent and acceptable with the experiences and perspectives of the knowledge translation group. Findings from all four consultations were shared with the Working Group for feedback, culminating in this final report.

WHO PARTICIPATED?

For the three WC sessions, half of the participants identified as male, over 40 %female, and a few identified their gender as Two-Spirit or non-binary. Seven of 38 participants identified as part of an LGBT2SQ community or identity. All but one participant was born in Canada and 16 people identified as **First Nations**, 11 as **Métis**, 9 White, and 2 Latin American. The ages of participants ranged from 19 to 71 years with an average age of 39.

Participants were asked to indicate the **places they generally stayed or slept** in the last month and their responses indicated significant challenges with housing and shelter. Of the 38 participants; 17 generally stayed or slept in their own homes, **15 reported staying outside, 10 in a shelter**, and others in a range of places including with friends, partners, different places every night, or avoiding sleep because they did not have a safe place to do so. **Thirty** participants considered themselves to **live in the inner-city** of Winnipeg, 8 participants identified as living in suburban neighbourhoods; 17 had been living in their current neighbourhood for over 5 years, 10 had been in their neighbourhood for 1-5 years, and 9 had been in their neighbourhood for less than one year.

The **places and spaces in which people consume drugs** were of central interest to this consultation. Participants were asked to indicate where they usually use drugs. The most common response was **outdoor drug use** (27 of 38), followed by 'my own home' (17), public spaces (16), someone else's

home (14), in a vehicle (12), and a range of different spaces. See Appendix B – Table 2 for results.

In addition, the demographic questionnaires were designed to gather general feedback on the relative **likelihood of accessing a variety of community-based services**. The types of services asked about were submitted by organizations that serve people who use drugs, and consisted of both currently offered services with an eye to expansion, or services under consideration for wider support or development.

The services that participants rated most likely to use included; **recreational services** (89.5%), **rapid access addictions medicine clinics** (84%), **better access to harm reduction supplies** (82%), and **supervised consumption services** (81.5%). See Table 1 for response frequencies.

The above relative weighting can help gauge where supervised consumption services may land in relation to other services these 38 participants would be likely to use. However, this brief summary is not intended to be generalized to a wider population nor to represent an adequate consultation regarding any of these additional services.

Participants' needs for safe spaces extended far **beyond places for drug consumption**. Participants described the lack of safe spaces to be high, to live, sleep, have fun, and to access care and services. This consultation on spaces of drug consumption was not equipped to capture the wider needs of those who shared their knowledge and experiences. Further, the characteristics of desirable safe spaces are shaped and experienced differentially along axes of race, social class, gender, sexuality, ability, and other categories of social privilege and norms. These intersections are beyond the scope of this consultation.

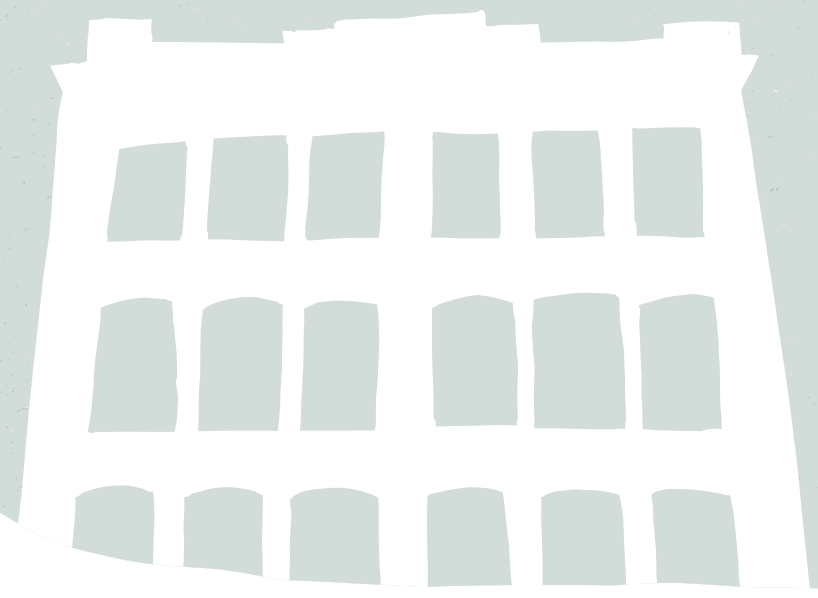
It is important to note that people generally consume drugs in the pursuit of benefits, and many benefits can be derived from drug use, such as sociability, pain relief, energy, or sedation (Morgan, Noronha, Muetzelfeldt, Fielding & Curran, 2013). However, this consultation did not specifically explore drug-related benefits.

TABLE 1. REPORTED LIKELIHOOD OF USING SELECT SERVICES

	NOT LIKELY LIKELY	LIKELY OR VERY LIKELY	NA
RECREATIONAL SERVICES AND PROGRAMS	8%	89.5%	2.5%
RAPID ACCESS ADDICTION MEDICINE CLINICS	16%	84%	nil
BETTER ACCESS TO HARM REDUCTION SUPPLIES	18.5%	81.5%	nil
SUPERVISED CONSUMPTION SERVICES	18.5%	81.5%	nil
BETTER ACCESS TO OPIOID REPLACEMENT	37%	73%	nil
BETTER ACCESS TO EARLY PSYCHOSIS TREATMENT	26%	71%	2.5%
TRADITIONAL HEALING OR CULTURAL PRACTICES	29%	66%	5%
DRUG CHECKING SERVICES	39.5%	58%	2.5%

"I CAME OFF 90 MG OF METHADONE WHEN I WENT TO JAIL, BECAUSE I MISSED TWO DAYS AND I GOT PICKED UP, AND THAT WAS THE WORST, THAT WAS A ROUGH 2 WEEKS IN JAIL. IT WAS WORSE THAN MORPHINE, IT [WITHDRAWAL SYMPTOMS] LASTS LONGER."

- PARTICIPANT, ON THE SUBJECT OF: STRUCTURAL VIOLENCE: DRUG PROHIBITION, CRIMINALIZATION, IMPOSED FAMILY SEPARATION, AND GENERAL INTERFERENCE



CONVERSATIONS ABOUT HARM: *SAFE FROM WHAT?*

Most of the safety concerns that arose in conversations with participants applied to all types of drug consumption spaces, not just SCS. Exploring perspectives on safety naturally requires an exploration of what is harmful. Participants described significant sources of harm in the social and material environment that contributed to decisions about consumption spaces, and that shaped practices within consumption spaces.

Some of the **key characteristics that contribute to harm** were not the drugs themselves but the social world that surrounds the lives of people who use drugs. **Key themes included:**

- Structural violence – drug prohibition, criminalization, imposed family separation
- Stigma related to drug use
- Trauma, pain, loss, and discomfort
- Community violence
- Lack of social and material resources
- Drug expenditures and exchange
- Nature of the drug market and scene

STRUCTURAL VIOLENCE

Drug prohibition, criminalization, imposed family separation, and general interference shaped the spaces of consumption and the conditions for harm within consumption spaces. The fact that drugs are illegal creates conditions of criminal justice system involvement. Many participants had significant contact with the criminal justice system that resulted in physical harm, separation from family, and lost opportunities.

"I came off 90 mg of methadone when I went to jail, because I missed two days and I got picked up, and that was the worst, that was a rough 2 weeks in jail. It was worse than morphine, it [withdrawal symptoms] lasts longer."

"Me holding a rig in my hand in front of a cop does not bother me. Me holding a bag of dope in front of a cop, that's different."

Apprehension of children due to drug use arose as a key condition for harm and problematic drug use. Participants also shared difficulty accessing shelter and housing, and being refused services because of their drug use.

Outdoor drug use is highly **susceptible to disruption and harm** from other people. Although disruption and arrest from police were concerns, fear of disruption extended to

any people in the vicinity of where someone uses drugs. Being seen by people could result in harm such as discrimination, being judged, yelled at, evicted, jumped, robbed, raped, or otherwise assaulted.

"People, cops, depending on exactly like – you know, if you're under the bridge, if you're by the park. Like I say, people walking by with dogs. You know, you don't want a dog running up to you and you've got some dope in your hand and you're trying to cook, and he knocks you over or some shit."

"If you're in the public and you're cooking your morphine or whatever, and security guard comes or someone, it's ruined you know? It's just a waste of money cause they're just going to call the police to scare you, or you're just going to screw it up or whatever from rushing. So it's better to be somewhere safe anyways. Where somebody's not going to come in and try to take your drugs or slap them on the ground or steal them."

"So, I mean if you're in a park using that and some security guard comes and chases you and you've got to drop $40 on the ground you're going to be pretty mad, and pretty dope sick on top of it."

There were different experiences and perceptions among participants regarding patrol organizations (Winnipeg Police Services, BIZ patrols, Winnipeg Police Service cadets, Bear Clan, Mama Bear Clan). Some participants expressed that patrol organizations, specifically Bear Clan/Mama Bear Clan, contributed to the safety of people who use drugs outdoors. Participants had mixed experiences with police, who were considered more threatening if a person has outstanding charges or is in breach of a conditional or community-based sentence.

STIGMA

Stigma is a significant force that shapes the lives of people who use drugs. Participants shared concerns about judgement and differential treatment by many kinds of people including service providers, neighbours, employers, and family members.

"And you don't want to see someone who doesn't do it, seeing you do it, right? Because then they're going to judge you, right? And it's embarrassing."

"What's normal to us in our circle of friends is not normal to the general public, you know?"

"[I use alone] because the shame. Home. My place. It goes back to shame, I don't want people to know. I keep it to myself. I don't want other people seeing it."

"We try to hide it because we were embarrassed about it. And I get that; I'm not proud of the fact that I stick everything in my arm, but ..."

"At my parents' house they might find out [that I use]. Like people have big mouths, and it would just kill them. They would be so disappointed and I don't want to hurt them. I don't need them catching me."

"Well, because the stigma behind it, you know? If they see you using they'll say you're a dirty junkie and blah, blah, blah."

Stigma also exists between people who use drugs, with some types of drugs or routes of consumption, and contexts in which these drugs are consumed, being perceived or experienced as more stigmatizing.

"What I find is people judge you right away. Like I'll go in a bar and do a line or whatever, like my old bosses and stuff. But as soon as they know you stick needles in your arm that's it, you're a dirty junkie right? I'm thinking what's the difference? It's the same thing, same drugs."

Stigma also had social class, racialized, and gendered manifestations. In particular, women and mothers were identified as being judged differently.

"Or if they're brothers or sisters...They're okay [to use], but not me. It's the mom thing I guess, maybe."

Unsafely discarded needles and public injecting were found to contribute to stigma and harm to people who use drugs.

"And it makes the city look even worse when someone sees you doing it out in the open. It makes the city look worse and it just gets people more mad, right?"

And many participants described actively engaging in clean-up of discarded needles.

"If they just want to chuck and stick it in the ground, I'll grab it after them. Whatever, right? No biggie."

"I always pick up [needles] and I'll hold onto to them until I find somewhere to put them. A lot of junkies agree with that, that leaving rigs lying around like that is just absolutely disrespectful. It's disgusting. They're just making us look worse than what we are."

TRAUMA, PAIN, LOSS, AND DISCOMFORT

Trauma, pain, loss, and discomfort was commonly experienced by participants and contributed to problematic use and drug-related harms. Further, participants described other forms of suffering and discomfort including withdrawal symptoms, boredom, physical pain, and cravings, which shape spaces of drug consumption.

"[If] you're outside and you score off somebody and you're dope-sick, you're just going to go to that corner behind the... or in the park behind a tree to use. So I think being dope-sick has something to do with it, depending on how strung out you are, you know?"

VIOLENCE IN THE COMMUNITY

Violence in the community was a key concern when it came to the consumption space itself, or traveling to and from consumption spaces. Violence is often a symptom of poverty and the multiple stressors that come along with it.

"Then I got jumped one time at 1:00 in the afternoon on Des Meurons, which is a busy street; not one person saw it to see if I was okay."

"Well, you got to take your chances, right? Especially when you're on Main Street. You have to keep an eye out for whoever's coming, you know?"

"I overdosed and got beat up at the same time in a bathroom"

DRUG EXPENDITURES AND EXCHANGE

Drugs can comprise a significant expenditure. In particular, participants noted a significant rise in the cost of diverted prescription drugs.

"The price [of prescription drugs] has almost tripled in two years. Greys [morphine tablets] used to be $15 bucks, now they're like $54."

Sharing is part of the landscape of drug use. Sharing drugs is common when people are using together, or helping out someone who is experiencing withdrawal. Providing a cut of your drugs in exchange for using someone's space for consumption is also normative but not always desired – and for some participants, this expectation significantly influenced the consumption environment.

"I use at home a lot, but lost every single friend I've ever had...part of it is that I'm crazy and I don't want to share my drugs with anybody."

"It's better when I'm alone because then I don't have to share."

Exchange, or a cut of drugs, can also expected for services such as assisting with injection/ 'doctoring'

"Yeah like it usually costs half a point [to be doctored]. Or, if she's cutting up Percocet it will be two bumps [small pile of powder] or lines of Percocet."

However, for some participants, sharing was considered to be something positive and a way to contribute to community.

"We get each other back. What goes around comes around, we help each other out. One day I won't have something [drugs], and a friend will help me out. One day I'll have something and she won't. So we all do that with everybody in the hotel, because almost everybody I know in that hotel has some kind of addiction."

Finally, drug expenditures can involve income generating practices that are illegal, stigmatized, and dangerous, and the harms of these activities can be greater than the harms of drugs.

LACK OF SOCIAL AND MATERIAL RESOURCES

Some participants described a lack of social resources for safer drug use, such as helpful people around who could provide support, reverse overdose, assist with consumption/injection, and/or provide reliable information about safer drug use. Experienced people who use drugs were seen to hold valuable knowledge that had not filtered through to younger, newer people who use drugs.

"The older ones [people who use drugs] are more experienced and they have more of a knowledgeable understanding of using in a privatized space such as their own homes. The younger generation they don't have that, and most of the younger generation who are stuck in this atrocity are homeless."

However, some participants expressed that, at times, they may receive conflicting messages, and/or may question the validity of the information they receive.

"I don't think anyone there [downtown hotel where drugs are used] is smart when it comes down to their craft or whatever. They kind of know what they're talking about but you get one person will say this and one person will say that. That can scare you because I only started doing intravenous in January, and first I heard about the air bubble, 'it can kill you' I was told, like that much air 'it can kill you like that'. Then was told you have to mix the whole thing [syringe] with blood... I don't know what's what."

"It's mythology. No one there knows. They all pretend they know 'oh I've been doing this for 28 years' or whatever. And you're still not sure?...But with drugs, no one seems to know."

In addition to social resources, similarly, material resources for safer drug use were often not accessible, such as sterile injection supplies, adequate surfaces for drug preparation, clean water, or take home naloxone.

NATURE OF THE DRUG MARKET AND SCENE

Participants were tuned into dynamics in the drug market that can contribute to harm, such as the unpredictability of products from an unregulated market, particularly since the emergence of fentanyl.

"I'm not going to try fentanyl because you know you're only going to get one little bit too much and you're dead."

"Some people say 'I'm going to go to Vancouver and try every drug there is'. But when I get there I sober up cause I don't trust the scene."

"We did some stuff and I didn't know what was in there, and I fell asleep. I don't usually do that. But he knew what to do, he had it [naloxone kit] from the north end there.

In addition to changes in the type and quality of drugs, changes in the practices and modes of drug consumption, particularly a rise in injection drug use, were shared.

"We've got needles – needles weren't even around, when was it? They were big in the '80s, then crack came around, but now they're making such a big comeback because everybody's putting everything in their veins...– I never even thought I'd see that here. A few years ago people were calling me 'gross' because I did needles. Now everybody's doing needles."

"A lot of people don't know how to inject so there's other people injecting [them], and that's another risk that you're willing to take, right?"

In sum, many participants experienced harms from the institutional environment by way of exclusion, punishment, differential treatment, or denied access to social and material resources, often based on their drug use. Poor access to resources contributed to less safe environments for everyday life practices, including drug use. For many, SCS **were seen as an opportunity to have a space where people who use drugs feel welcomed and included, where harms of the social environment can be avoided, and drug-related benefits can be enhanced.**

"Yeah, you're feeling safe and maybe a better high. And you can't get busted."

For others, the key reason for SCS was "*to clean up the streets*". This perspective is more consistent with the perspective that SCS would remove people who use drugs from public spaces and reduce discarded needles.

DESIRABLE SAFE SPACES FOR DRUG USE

Our methods drew from participants' everyday experiences of drug consumption spaces, as well as from their perceptions or imagination of drug use in spaces they do not, would not, or cannot use in. Regardless of the type of spaces where people use drugs, people described desirable safe spaces for drug use as **welcoming, private, convenient, well-resourced, clean, physically and socially comfortable, and sheltered from law enforcement, discrimination, coercion, disrespect, judgement, violence, and other harms**. When people talked about safety, their considerations included their own safety, and the safety of the people and communities around them – specifically the safety of children and youth.

Navigating drug use environments is a complicated social practice. Safety is always a priority for people who use drugs, however there are inherent tensions between different characteristics of safe spaces. Various desirable characteristics of spaces for drug use are more important to some people than others, and some desirable characteristics may be more important to people at different times. For example, the desire to avoid sharing drugs may become more or less important than using around other people who could provide support or company.

"I usually do [drugs] by myself. I don't use with anybody. I'm too cheap with this stuff, everybody's too cheap... I still feel lonely, like I wouldn't mind the company, but people are too cheap."

Participants were provided with a simple definition of SCS but were not provided with a detailed explanation of the Health Canada regulations that govern what is possible within legally operated SCS **Over 80%** of the people who participated in this consultation reported they were **likely or very likely** to **use SCS** and conversations were held to capture their perspectives on how SCS ought to be offered and organized. Participants' use of SCS would be provisional upon the way the services were provided and experienced. Thus, a **peer or service user advisory body would be essential** to inform the development and ongoing operation of such a service.

The following findings are organized according to some of the **general characteristics of desirable safe spaces for drug consumption**, whether the space is residential, public, or professional. The **implications of each of these characteristics for SCS** are discussed. Lessons learned for enhancing safety when using drugs outdoors, in private residences, and in public washrooms are shared at the end of this report.

The following ten characteristics of desirable safe spaces emerged from conversations:

- More than just a space to consume drugs
- Human support, services, or helpers available
- Convenient and easy
- Familiar and promotes autonomy
- Calm and comforting
- Clean and materially resourced
- Private and low profile
- Away from children or places children congregate
- Safe and secure
- Rules, norms, and/or guidelines are respected

MORE THAN JUST A PLACE TO CONSUME DRUGS/ACCOMMODATES OTHER NEEDS

Participants shared that they generally lacked safe spaces for many aspects of everyday life, including a safe space to sleep, eat, receive services, meet with friends, be high, and engage in the things people like to do when they are high.

"A place where you can be afterward, have coffee or something to drink, perhaps recreation."

These needs varied according to the individual, but also the type of drug used. Some participants who used opioid drugs sought comfortable furniture in a post-consumption space.

"Oh yeah, for me a couch [is good] because I pass out all the time"

Others recognized that someone who uses stimulant drugs may be more active and require more physical space.

"In case you are doing the chicken [shakes or fitting] there."

For those who use drugs outdoors, accommodation of other needs, such as electricity to charge a phone, heat vent/output to stay warm, and seating was highly valued.

Implications for SCS: Participants suggested a post-consumption space for snacks, recreation, showers, storage, and a safe space to be high. A space that promotes social interaction, belonging, and community was generally desired, and/or an opportunity to become involved meaningfully through employment or volunteering. In particular, recreation and leisure were commonly discussed as important elements in SCS.

"Something to do when you are high – chalk board or white board – some way to express and create artistically."

"A sense of community among people that go there – recreation would help."

"If I had a friend there with me, I would totally like that. I would like there to be a couch where I sit with people to hang, you know, maybe games along with the enjoyment of using."

"They should have snacks there. So if you get the munchies."

"That would be nice if there was a nutrition – I guess whatever it is. You get something nutritious. Let's say apples and oranges or something. Some electrolytes because of our thirst."

ACCESS TO HEALTH AND SOCIAL SERVICES. Valued health and social services were discussed by participants, such as support with housing and shelter, traditional or cultural practices and healing, income or employment assistance, primary health care, child care, and addictions treatment. Secure storage, or being able to bring your belongings in with you was also identified as important:

"Maybe lockers to put your stuff, being able to bring your stuff with you and you can leave it there, so when you go back you have your stuff."

Participants suggested a SCS should be attached to a site that offers other services and resources, however, the nature of these desired services was not fully captured – further consultation on this topic is recommended. Most of the participants identified as Indigenous, and there is health evidence that affirms the importance of culture-based prevention and treatment programs to address problematic substance use in Indigenous communities (Rowan et al., 2014). In addition, access to social and health services (housing, income, counselling, addictions, detox, harm reduction) in a manner that is culturally safe, harm reduction grounded, and trauma-informed or healing centred would be consistent with participants' desire to be understood, welcomed, and not judged. The majority of participants (66%) stated they would be likely or very likely to access traditional or cultural practices or healing.

"I would say attached [to a health service] just because it would be easier to find resources because they are there already. It is not like you have to leave, and then go all the way over there."

HUMAN SERVICES, SUPPORT, OR HELPERS

Human support or services of various types were recognized to contribute to safety in all spaces where people use drugs. Participants shared their perspectives on the specific skills, required tasks, and qualities desired of a support person in the existing spaces of drug consumption.

Desired tasks included:

- **Overdose designated** responder (in case of an injection error or overdose). Drug overdose arose as a key concern primarily, but not exclusively, related to opioids because of the immediate life threatening nature of an opioid overdose. While many participants shared that they know what to do in an overdose and carry naloxone, it was still expressed that a support person should be able to intervene in the case of overdose.

  "Always there had to be a sober person, just in case anything went wrong."
- **Injection assistant** or 'house doctor,' to assist with helping people to inject their drugs

  "[My girlfriend] is hard to hit so, one time she spent six hours trying to hit it [vein]. And I just watch her, uh it made me sick, and she'd want me to run go get that person and this person to hit her."
- **Safety/security** personnel or a **lookout person:** Someone to 'keep six' [keep on the lookout] for anyone who may be in the area to disrupt use or rob/assault a person
- **Rule keeper**, rule communicator, or enforcer
- **Knowledge sharing** related to safer drug consumption
- **Child minding** or someone to keep children separated from drug use activities

Implications for SCS: Human support and services is a key feature of SCS. **Relevant life experience** was seen to make support people less judgemental. For most types of support, participants expressed that a peer or person from their own social network or location was considered best.

"I found that the ones that have life experience are a lot more, they have a lot more empathy, and people they are talking to they don't feel judged."

Participants had different perspectives on the best type of person to act as an overdose responder or consumption attendant in SCS. In addition, SCS should build on and include community knowledge.

"[I USE ALONE] BECAUSE THE SHAME. HOME. MY PLACE. IT GOES BACK TO SHAME, I DON'T WANT PEOPLE TO KNOW. I KEEP IT TO MYSELF. I DON'T WANT OTHER PEOPLE SEEING IT."

- PARTICIPANT, ON THE SUBJECT OF: STIGMA

"I would prefer a person to be a user than anybody else. The fact he knows what is happening, he knows what is going on. I don't think that a person should be there and run home and say 'you should see those bunch of junkies!', you know what I mean? I would prefer a user. That is my own opinion."

"Yeah, not people who took a course, you know – they won't understand you, right? People who would run it, I would say, have to be people who've had the experience, who've experienced that lifestyle for a while."

To this end, some participants valued SCS as a potential place for employment opportunities for peers.

"But I mean, like if you were going to hand out jobs, it would be an alright job. I'd take a job cleaning up after, making sure . . . You know, it would be a nice – it would be a good job."

However, some participants preferred that the consumption attendant be a health care professional.

"I would much rather prefer an actual like health specialist, like a nurse practitioner or even a counsellor. That would be cool."

Staff working in SCS need to be acceptable for the people using the services and should be well versed in harm reduction approaches, cultural safety, Indigenous cultural services, trauma-informed or healing-centred care.

Of note, there were key features that were important to many participants that are challenging or prohibited within the current legal framework set out by Health Canada regulations. These issues such as assisted injection, peer operation, and drug-splitting, are explained further in the following three sections.

ASSISTED INJECTION. Many people require assistance with drug preparation and injection; and requiring help to inject has been associated with greater drug-related harms such as HIV and hepatitis C infection, injection-related infections, overdose, and experiences of violence (McNeil, Small, Lampkin, Shannon, & Kerr, 2014). Women, youth, and people with disabilities are disproportionality represented among those requiring assisted injection (Kral, Bluthenthal, Erringer, Lorvick, & Edlin, 1999; Wood et al., 2001). Health Canada regulations prohibit assisted injection/consumption in supervised consumption services that operate under a federal section 56 CDSA exemption.[1]

Assisted injection was a robust topic of discussion among participants and a common service in natural drug consumption spaces.

"I have a hard time [injecting myself], and I like it better when someone else does it."

To facilitate assisted injection, some participants described seeking out public washrooms that accommodate a second person.

"He can't shoot, my husband can't shoot himself. I have to go with him. The single [stall] ones, even then you have people looking at you. I mean I want to be able to go somewhere and not be..."

Participants suggested assisted injection would be a valuable service to make available.

"Like a [house] doctor...To come over to fix you... yeah. That'd actually be smart, that'd actually be cool."

"That would even be helpful, even having a vehicle like that where you can jump in the back."

1. Currently Montreal SCS are piloting assisted injection; see CBC News (2018, June 18) Visits to Montreal's supervised injection sites more than doubled in first year. Retrieved from https://www.cbc.ca/news/canada/montreal/montreal-safe-injection-sites-visits-doubled-1.4710839

PEER VERSUS PROFESSIONAL OPERATION. Health Canada regulations require SCS to designate a responsible person in charge on site (in the building, on the same floor) who is able to provide a satisfactory criminal records check, and hold professional designation. Attendants at SCS do not need to be regulated health professionals, but other training must be provided. These regulations promote a more clinical or health professional model of supervised consumption that is not consistent with the desires of many of the people consulted.

DRUG SPLITTING AND SHARING is common among participants who pool resources to buy drugs, between intimate partners, or to efficiently use up trace drugs left over in the preparation/consumption process.

"If I'm with a friend, I'll be with one or two people, but then we're all sharing, like we're all sharing cost, all getting equal units or, you know."

"I usually get about 100 mg a day. I cook it, I get the first cook, and then she gets the wash, it's called, then I cook it a third time. That's it, there are no arguments."

Splitting and sharing is prohibited in SCS under Health Canada SCS regulations. This prohibition may be a barrier to SCS use among those who split and share drugs routinely.

CONVENIENT AND EASY

People use drugs as a part of everyday life and so drug use often occurs where people work and live.

"If I'm dealing outside, I use outside."

Participants preferred low-threshold spaces that were available when and where they needed them.

"It's not only who you really trust, it is where you can really go."

For many, timing determined the space of when and where drugs would be consumed, rather than access to a more desirable space.

"I do wherever man, outside even."

"I mostly use at home, but I'll use washrooms sometimes if I'm out."

Implications for SCS: Reducing barriers to service for people who use drugs (often termed 'low-threshold,' Islam, Conigrave, & Day, 2013) is a key feature of harm reduction. While some participants suggested that the city should start with one SCS site to see how it goes, a number of participants suggested that in order for SCS in Winnipeg to be accessible and convenient, there should be more than one location. Suggested locations were primarily in the inner-city, away from where children congregate, away from law enforcement, and offering the widest operating hours possible (ideally 24/7). Main Street near the Access Centre, Downtown, the North End, Point Douglas, the West End, and Elmwood were specifically suggested neighbourhoods.

"Oh, they would need more than one [SCS]. For sure, more than one."

"A core area where most people score."

"It should be open 24 hours."

"Yeah, not on a residential street or something, like Downtown."

"Away from children and away from residential neighbourhood."

"Worst place would be near a cop shop. You can get busted for drugs."

In addition, a number of participants suggested mobile SCS.

"In Barcelona, they have these little buses and you go on there and they have like just two sites set up, like the little desk type thing."

FAMILIAR AND PROMOTES AUTONOMY

Being familiar with, and having control over your surroundings was important to participants, and spaces that facilitated drug consumption routines accommodated safer practices. Many participants indicated they primarily use drugs at home. "Home" was considered a familiar space that you are oriented to, that facilitates your own routine, and that you control.

"One time I injected it and kind of had lights out, like a black out. I know my home cause it's my home, and I knew where to find my phone. I knew where to get water."

"Well when, you know, when people get up, they go to work they have their coffee, their routine, everybody's got their routine - so does a junkie. They got their routine, they get up, they have their spoon set up, it's the exact same every time. So it just feels more comfortable. I always do it at home. I don't do it anywhere else...well if I have to."

Implications for SCS: Creating a service space that feels familiar, that provides service users with a sense of control, and facilitates people's drug preparation and consumption routines is particularly challenging for SCS. The desire for familiarity and autonomy over space would likely be a key barrier to the use of SCS for some people. The more that people who use a SCS are involved in organizational and service delivery decision making, the more likely a SCS could be tailored to meet the needs of familiarity and autonomy.

COMFORTING AND CALM

Participants expressed preferences for spaces that are devoid of disruption, such as jarring sounds, loud knocking, yelling, or slamming doors.

"How can you inject yourself if they are always coming in?...I am always paranoid."

"Don't bang on the door if I'm trying to shoot."

"So long as there are no people yelling."

Due to the fear of disruption, outdoor use was inherently more rushed.

"Wherever I can have a place to hide... a little fix and split."

"If I'm in a place where I feel safe and comfortable I'll stay. But otherwise yes, slam and scram."

Many participants expressed that home was a calm and comforting place to use drugs:

"Part of it is also I have time, I can do my own thing. When you're out it always seems chaotic for some reason. I'll use when I'm out if I'm with somebody who is using with me at a party or whatever."

However, home is not always private and calm. This was particularly of concern when other people may be looking to share your drug supply.

"At the [hotel], I don't like doing it there because everyone uses there and they knock on your door if they know you have, wanting to borrow or spot. I don't like doing it at home."

Implications for SCS: SCS should be calm and comforting by way of lighting, sound, furniture, and human relations. In imagining SCS, participants suggested calming imagery (such as an aquarium, paintings, plants), soft lighting (outside of the injection space), and comfortable temperature and furniture.

"A good couch...or a reclining chair."

"Something that makes them feel safe and comfortable."

While some participants preferred music or background sounds, some people expressed that they would be very distracted by sounds or types of music they don't like.

"I like to shoot up in silence."

"I don't listen to music when I do it. Not everyone has the same taste"

Social and interpersonal implications of comfort also arose in conversation.

"It should be as comfortable as possible, like not people that are going to look down on you."

CLEAN AND MATERIALLY RESOURCED

Drug preparation and consumption materials (sterile needles, cookers, filters, alcohol swabs, tourniquets, clean or sterile water), need to be accessible in drug consumption spaces. In addition, resources such as good lighting to assist with injection and adequate spaces and surfaces to prepare drugs were identified as important.

"You need lighting, if you don't have lighting, you're gonna miss [vein]."

"A good surface to prepare drugs on."

Similarly, spaces for drug consumption should have options for safe needle disposal, and first aid/emergency resources (wound care, naloxone). Without easy access to sterile injection supplies it is common that people will share injection equipment.

"Me and my boyfriend share [needles] if we're on our last one."

Participants recognized outdoor use as less resourced (lack of access to lighting, clean water, drug preparation surface, sterile injection supplies and needle disposal) making it more difficult to attend to safer drug preparation and consumption techniques. However, outdoor use provides the benefits of convenience and autonomy, and avoids the need to share or exchange drugs for access to space.

Implications for SCS: In addition to the resources described above, participants suggested SCS should be regularly cleaned, able to distribute injection supplies (whether a person is staying to consume or not), and provide safe needle disposal options.

"I'd want it to be clean, like lots of stainless steel, like lots of stainless."

Other suggestions related to temperature. Of particular concern in the winter months was a way to warm veins and hands to facilitate injection.

"I have to warm my hands up in hot water first for a while and then I can [inject]."

"Even just a face cloth that we can run it under hot water."

Mirrors are often placed in cubicles of SCS, and help the attendant observe service users to determine if assistance may be required. Participants had varying perspectives on mirrors, and some people expressed being quite distracted by them.

"[Mirrors] make people stay way longer because they would look at themselves, oh fuck, and they stay there for hours. Distracting, can freak you out."

In SCS there should be options that don't require a person to sit in front of a mirror.

"Yeah, so maybe some mirrors and some not mirrors."

PRIVATE AND LOW PROFILE

Whether using drugs in a private residence, outdoors/public spaces, or SCS, participants generally advised that it is **unhelpful and unsafe to draw attention to the fact that drugs are being consumed**. Many participants shared that everyday practice involved efforts to "fly under the radar" when it comes to drug use. Loud parties may lead to negative consequences such as eviction and arrest in private spaces of consumption.

"MAYBE ... YOU DO YOUR SHOT THEN YOU CAN GO AND HAVE LIKE A COFFEE OR JUICE AND HANG OUT, ... LIKE A HALF HOUR LIMIT OR SOMETHING, THEN YOU HAVE TO BE OUT. SO WE ARE NOT HANGING OUT FROM MORNING TO NIGHT TYPE DEAL, UNLESS YOU GO BACK FOR ANOTHER SHOT."

- PARTICIPANT, ON THE SUBJECT OF: TIME LIMITS

"I would prefer an isolated one [space]. I don't want anyone around it. Where nobody looks at you. I try to find the perfect place."

"I would be concerned about people walking in and looking at me, seeing that I am doing a shot."

"I just keep the noise down, and watch out."

"I like it to be like kind of hidden actually, so nobody sees."

"Either in the street, or the park, or anywhere where there is a little bit of privacy."

Privacy was a central feature of many participants' homes that contributes to safer drug use.

"It's nobody's business what you inside there, behind your door, like your landlord or, and you don't have to answer the door."

"I want to be able to go home and relax. Well people use drugs to relax, particularly opioids, but I wouldn't want anyone there bothering me."

Implications for SCS: The social response to drug use was seen to differ for women, parents, youth, and homeless people, and the resulting harms are distinct. The spatial organization of SCS should be attentive to privacy concerns.

"I was going to say they [SCS] should be private, yeah. I don't want to see – I don't want someone to see me doing what I'm doing."

"You know, it would ultimately be better if there weren't cubicles; everybody had their own little space they could close the door and do it in there. But I think that might be out of the question but that would be the best."

Some participants suggested embedding SCS in an existing service space that provides a range of services so that a person entering the building would not automatically be recognized as a person who uses drugs. This suggestion also would be congruent with earlier recommendations by some participants to have SCS in conjunction with additional services. Some suggested very little signage to not draw undue attention.

Health Canada regulations require that each individual registers when they enter SCS. This requirement was discussed by several participants and not considered a significant barrier, provided a system was in place to streamline access after the initial registration.

"You register and they would have it on their computer."

"Your own codes, like a nickname or whatever, and they'll put it in a computer so they know who that person is. He's coming in and then it's their turn to go in."

AWAY FROM CHILDREN AND PLACES CHILDREN CONGREGATE

Across all conversations about drug use spaces, protecting children and separating children from drugs and drug consumption were key concerns. In general, participants expressed that they avoid using where children are or where they may be (such as near schools or parks).

"If there were kids, no, I am not using here."

"I won't do it if I see kids coming around."

"Schools and playgrounds, I believe that should be a no-no. I see lots of needles on playgrounds and it really drives me nuts."

Separating children from drugs in private residence was considered challenging when children live in a home where drugs are used. Some participants shared that they keep their drugs and sharps in a lock box, and physically separate drug use from children in the home by preparing drugs and using them in certain isolated spaces (bedroom, shower, bathroom), or at certain times of day when the kids were not around.

"Usually I'd use at morning then at night. I have three kids. I used in the shower."

Participants shared their experiences of monitoring their drug use while parenting, and coming off of drugs was identified as a very difficult time that can get in the way of taking care of children.

"Your body goes through a lot and they [children] see that and they feel that. You're at a point where I had to give them to Child and Family Services because I didn't want them to go through that – they go through what I go through and they had seen enough. Me not cooking, depressed."

Implications for SCS: Participants recognized the needs of parents who use drugs while upholding the value of separating children from drugs, and the complexity of balancing these needs.

"You can't do it [drugs] in front of them."

"Just don't bring your kids along when you're having a shoot up, you know? That's the only thing that shouldn't be allowed."

"So I'm just thinking, if you have children, you can't judge. There are people out there that use and maintain."

"But you can't just keep on living on the street with your kid and just keep on going there [SCS] to inject. Then you shouldn't have those kids."

SCS in Canada are used considerably more by men than women and other genders (Potier, Laprévote, Dubois-Arber, Cottencin, & Rolland, 2014). This consultation did not capture the specific needs of women and other genders, however, parenting and childminding is likely among these needs. Flexible child minding at a location nearby, but not within, SCS may help meet some of the needs of parents who wish to access the service. Age of SCS entry is discussed further under rules and regulations.

SAFE AND SECURE

A number of safety and security concerns arose in conversation, mostly in relation to SCS. Participants' safety concerns were related to the activities of people when they are high, being bothered for drugs, getting jumped or robbed for their drugs, and dealers and territorial concerns were mentioned by a few. The role of police, cadets, and patrol organizations within SCS were common topics of conversation as participants had mixed experiences with these organizations.

The active high of stimulants was mentioned, and would require greater supervision needs in post consumption spaces. Opioids were considered to have greater safety implications during consumption due to the risk of opioid overdose.

"Yeah, because we also need to figure out about security, right? Some people when they shoot up they can be really chill or really aggressive and really crazy."

"So, we don't want there be any fights or stabbings."

"Some people get paranoid when they do drugs and they don't know what they're doing. They're stealing. I was just wondering what kind of supervision."

Participants also expressed concern that people without drugs at SCS would bother people for drugs.

"You don't want people hanging around there bugging other people or to see if they have drugs either."

"Yeah, you should have to maybe show that you have [drugs] before you're allowed in."

"You've got to make sure that people that have nothing can't just go there and bug other people, you know. That's going to be a major."

"That's just going to make everybody mad. People go to keep on grinding 'Can you spare some?'"

A few participants suggested that police, cadets, or patrol organizations could be helpful in the area near SCS, but not within the site, to enhance safety.

"Yeah as long as they [patrol organizations and police] don't get involved. As long as they don't get involved with what we're doing. Don't try and bust us or whatever."

RULES, REGULATIONS, NORMS, OR GUIDELINES

Expectations of social conduct in drug consumption spaces were considered to contribute to safety, especially if those expectations are reasonable, flexible, communicated, honoured, enforced, and developed in consultation with people who use the space. In existing spaces of drug consumption, participants described these expectations as guidelines rather than rules as they tended to have conditional flexibility depending on the person or situation. The rules or regulations that participants described largely reflected the attributes of safety described throughout this section. Participants were strong supporters of the following guidelines:

- **Respect:** *"When people disrespect that place it makes it feel less safe." "Respect for comfort and wishes, and people should ask about your comfort."*
    - **In private spaces, respect involved getting permission or consent to use drugs there:** *"Consent, I feel. Personally, I wouldn't go behind someone's back"*
    - **And, in private residences, the property owner's/renter's rules should be respected:** *"The lease owner makes the rules."*
- **No sharing drug use equipment**: *"I don't share. I don't use a spoon or whatever, I have a medicine bottle I put everything in, the water, I don't use that spoon."*
- **Clean up after yourself:** *"No used supplies lying around."*
- **Keep it private and low profile:** *"No loud parties." "I like it to be hidden actually so nobody sees."*
- **No children witnessing**: *"If my kids are at home stay away."*
- **Keep stocked:** sterile injection supplies, naloxone
- **Exchange**: compensating the space owner for the use of their space is a common expectation in private residences (usually a cut of drugs). *This would not apply in SCS*
- **Communicate the rules of the space**: *"It makes me feel that this is actually a place to use because they [those in charge of the space] understood what was going to happen. It makes me realize the responsibility of using."*

Participants shared different ways they had seen rules being communicated in private residences, such as being posted on the wall or written out on a piece of paper.

Implications for SCS: Participants felt that service users should be involved in the creation and maintenance of rules and regulations of SCS. In addition to the general rules above, time and age limits were discussed.

TIME LIMITS would apply to a consumption and post-consumption space. To accommodate difficult injection, most suggested 20 – 30 minutes in the injection/consumption space. However, participants expressed concern that some people may need longer to inject and/or some people may just use the space all day if there is not a time limit.

"And it depends if you have trouble fixing and stuff like that because some people take a long time, right?"

"Half an hour or something. Something that's relevant."

"I am one of those people, I can take hours to hit [inject]. I get that people may need the space, but if you feel rushed it is harder."

Time limits would also apply to the post-consumption space – some suggested 30-60 minutes as a reasonable limit.

"Maybe if there is a time limit on it. Something after you are in the booth and you do your shot then you can go and have like a coffee or juice and hang out, people have a couch and chairs but they give you like a half hour limit or something, then you have to be out. So we are not hanging out from morning to night type deal, unless you go back for another shot."

Participants also questioned how much drugs a person should be able to bring into SCS, and if a person would be able to continually cycle through the consumption and post-consumption spaces all day.

AGE LIMITS. Age of entry was a topic of much debate amongst participants. Most suggested a minimum age of 16 years for entry into SCS. Participants recognized that drug use often starts early and services should not be restricted to adults.

"If someone's going to be a drug addict, they start at the age of 12, right?"

"I was a junkie at 15 and if I had a safe place to go, it would've made my life a lot easier."

"If you look at it, it's all illegal anyways. It's all illegal so try to make it as legal as possible with the safest place as possible. You can't just turn them [youth] away. I don't think there should be an age limit."

Some of the lessons learned from this study may be applied to already existing spaces in which drugs are consumed. To this end, the following sections provide implications for enhancing safety when using drugs in public washrooms, private residences, and outdoors.

"ONE PERSON WILL SAY THIS AND ONE PERSON WILL SAY THAT. THAT CAN SCARE YOU BECAUSE I ONLY STARTED DOING INTRAVENOUS IN JANUARY, AND FIRST I HEARD ABOUT THE AIR BUBBLE, 'IT CAN KILL YOU' I WAS TOLD, LIKE THAT MUCH AIR 'IT CAN KILL YOU LIKE THAT'. THEN WAS TOLD YOU HAVE TO MIX THE WHOLE THING [SYRINGE] WITH BLOOD… I DON'T KNOW WHAT'S WHAT."

- PARTICIPANT, ON THE SUBJECT OF: LACK OF SOCIAL AND MATERIAL RESOURCES

ENHANCING SAFETY WHEN USING DRUGS IN PUBLIC WASHROOMS

Many participants reported regularly using drugs in public washrooms. This practice has been recognized locally by a number of health and human service organizations who have attempted to create "safer washrooms'" for people who use drugs. The World Cafe conversations provided a key opportunity to inform the design and operation of safer washrooms. Suggested characteristics and rules for safer washrooms:

AVAILABILITY

Operating hours of public washrooms are usually limited; ideally washrooms would be available at all hours.

"Open 24 hours in a publically accessible place."

Some suggest a small fee for use (50 cents)

PHYSICAL DESIGN

ACCESSIBILITY: All **gender wheelchair accessible washrooms** designed as **single rooms** are most desirable, particularly if you can bring another person in with you. A second person is especially helpful if assisted injection is required.

"I like the single bathroom idea the best. He can't shoot, my husband can't shoot himself. I have to go with him. The single [stall] ones, even then you have people looking at you. I mean I want to be able to go somewhere and not be..."

Multiple, cubicle-type stalls were described as less amenable to privacy and more monitored. In a multiple stall washroom, a lounge space within the washroom was desirable to some participants.

LIGHTING AND VISUALS: Particularly for individuals using intravenous drugs, good lighting was identified as an important consideration.

"Good bright lighting to assist with injecting."

Some participants shared that the fluorescent blue lighting used in some washrooms to deter injection (by making veins difficult to see) is not an effective deterrent; it just makes injecting harder and less safe.

PREPARATION SURFACE/TABLE OR COUNTER: Participants described the importance of a clean, flat surface where things can be set down, drugs can be prepared, and a place to sit to while using the surface.

"Like a clean countertop that you can bring up and down, so you can actually have a clean surface."

ADDITIONAL RESOURCES: A number of participants expressed that a shower would be valued.

EVERYTHING WORKS: Properly functioning components of a washroom were identified as important to participants.

"Don't run out of toilet paper and make sure the toilet works."

In addition, participants discussed that components of washrooms should be permanently fixed and not amenable to destruction or removal. Of note, there were mixed perspectives about the inclusion of mirrors:

"They make people stay way longer because they would look at themselves oh fuck and they stay there for hours."

DRUG USE SUPPLIES

SAFER INJECTING SUPPLIES: Participants expressed the importance of having access to supplies such as sterile needle/syringes, swabs, water, filters, cookers, and clean running water.

"[Supplies] available in the bathroom or nearby, or in a dispenser."

"Running water needs to be able to access – a tap you can control, and a way to filter the water, alcohol swabs."

SHARPS DISPOSAL CONTAINER: A needle disposal container would be required; some participants specified that a tamper proof sharps disposal would be preferred.

HARM REDUCTION & SAFETY FEATURES

HARM REDUCTION INFORMATION: A number of participants expressed value in making harm reduction and drug use information available within the washroom.

"Instructions on the wall about safe injection."

"Maybe have a list of resources on the wall, because a lot of people don't know the resources. "

"Something to watch or look at – like a screen."

EMERGENCY SAFETY FEATURES: The inclusion of a safety/emergency call button was viewed by participants as beneficial. Some suggested a security camera outside; however, some highly opposed use of security cameras. Additional safety suggestions included an automatic door lock that is set to a timer and would send an alert if someone had been in the washroom past the time limit. Another suggestion involved a walkie-talkie or intercom system to communicate with the person in the washroom.

OVERDOSE RESPONSE: Naloxone and general first aid supplies available.

SIGNAGE: Most participants agreed that there should be signage inside the washroom to communicate existing safety features to the person using the washroom. There were mixed perspectives about the use of a "safer washroom" label to make its availability publically known.

HUMAN SUPPORT: Participants expressed value in someone keeping an eye on the washroom to make sure the person inside is okay (only if the person checking in is aware that someone may be using drugs in the washroom and is there to be helpful). Again, an intercom system was raised as beneficial in the event of wanting to check on the person in the washroom.

GUIDELINES FOR USE

REASONABLE TIME LIMITS: Rushing is associated with less safe drug use practices. Participants suggested that time limits should be established to help keep people moving though; a guideline of 10-20 minutes was commonly proposed. Some suggested as long as 1 hour if shower facilities are

available. The time limit should be short enough so that if someone were to overdose, there would still be ample time to revive the person.

MORE THAN ONE PERSON PERMITTED: As indicated earlier, the ability for more than one person to use the washroom at one time, particularly when assistance with injecting is required, was perceived by participants as an important consideration.

ADDITIONAL CONSIDERATIONS

PRIVACY: Participants expressed that privacy is valued, and that steps could be taken to further increase privacy when using in a bathroom.

"Maybe a one-way window, you can see out but not in."

CLEAN: Participants indicated that the bathroom should be cleaned regularly by staff, but there could also be an option to clean it yourself before or after use. Wipes could be made available to clean the surface both before and after using.

SOUNDS: Music or something to mask any noises associated with drug consumption was mentioned, but the music should not be loud enough to obscure communication with the person in the washroom. Some participants indicated that they prefer silence. A number of people indicated that there should be no loud knocking on the door, or other jarring sounds, as they can cause injection errors.

FEEDBACK: Participants also expressed a desire to be able to provide feedback to the washroom owner/operator.

In particular, participants identified that washrooms in hospitals were considered favourable for drug use as they are large in size, may be used anonymously, and going in accompanied is not unusual as washroom assistance in a hospital setting is often required. These features accommodate the needs of people who inject drugs (including assisted injection) without drawing attention to them.

FOR MORE INFORMATION ON SAFER PUBLIC WASHROOMS SEE:

Vallejo, Melissa (2018) Safer Bathrooms in Syringe Exchange Programs: Injecting Progress into the Harm Reduction Movement. *Columbia Law Review 118*(4), 1185-1224. Retrieved from https://columbialawreview.org/content/safer-bathrooms-in-syringe-exchange-programs-injecting-progress-into-the-harm-reduction-movement/

Vancouver Coastal Health. (2017). *Overdose Prevention & Response in Washrooms: Recommendations for Service Providers.* Retrieved from http://www.vch.ca/Documents/Washroom-Checklist-Service-Settings.pdf

Vancouver Coastal Health (2016). Washroom Design and Monitoring in Vancouver Coastal Health Downtown Eastside Facilities: Principles and Recommendations. Retrieved from http://dtes.vch.ca/wp-content/uploads/sites/6/2016/10/VCH-DTES-Safe-Inclusive-Washrooms-Recommendations-Oct-2016.pdf

Wallace, B., Pauly, B., Barber, K., Vallance, K., Patterson, J. & Stockwell, T. (2016). *Every Washroom: De facto consumption sites in the epicenter of an overdose public health emergency*. CARBC Bulletin #15. Retrieved from https://www.uvic.ca/research/centres/cisur/assets/docs/bulletin-15-every-washroom-overdose-emergency.pdf

"IT'S NOBODY'S BUSINESS WHAT YOU INSIDE THERE, BEHIND YOUR DOOR, LIKE YOUR LANDLORD OR, AND YOU DON'T HAVE TO ANSWER THE DOOR."

- PARTICIPANT, ON THE SUBJECT OF: PRIVATE AND LOW PROFILE

ENHANCING SAFETY WHEN USING DRUGS IN PRIVATE RESIDENCES

Previous studies in Winnipeg have indicated that the vast majority of injection drug use (Wylie, 2005; Public Health Agency of Canada, 2006), and subsequently overdose (Manitoba Health, Seniors and Active Living, 2018), occurs in private residences more than any other space. Participants shared their perspectives on the benefits of drugs use in private residences and how to enhance safety in these setting.

For those with stable residences, home was often described as the most convenient and familiar space, notably because it provides autonomy and privacy.

"It's nobody's business what you inside there, behind your door, like your landlord or, and you don't have to answer the door."

However, for some people who use drugs, home was not always a private and controlled environment.

"At the [Downtown] Hotel. I don't like doing it there because everyone uses there and they knock on your door if they know you have [drugs] wanting to borrow or spot. I don't like doing it at home."

USING WITH OTHERS IN A PRIVATE RESIDENCE

Establishing, communicating, and enforcing rules can be challenging in private residences. Participants suggested the following guidelines:

FOR THOSE IN CHARGE OF THE SPACE

- **The resident, owner, or lease holder makes the rules.**
- **Communicate the rules of the space**. Participants shared different ways they had seen rules being communicated in private residences, such as being posted/written on a wall or on a piece of paper.

"It makes me feel that this is actually a place to use because they [person in charge of the residence] understood what was going to happen. It makes me realize the responsibility of using."

Note: The rules of use may change depending on the specific situation, especially if children are around.

"If my kids at home stay away."

- **Keep supplies stocked** including injection supplies, sharps disposal, and naloxone.

FOR THE PEOPLE USING IN SOMEONE ELSE'S PRIVATE RESIDENCE

- **Always ask before using at someone's place.** *"Let them [owner] know what you are doing."*
- **People in the space need to respect the rules.** *"When people disrespect that place it makes it feel less safe."*
- **Clean up after yourself.**
- **Don't draw attention to the space.** *"No loud parties"*

FOR EVERYONE

- **Don't share injection supplies.**
- **Share knowledge on safer drug use and how to respond to overdose.**
- **Designate a responder for overdose or other emergencies:** Have a designated person to respond to overdose, and/or stagger drug use so that someone is always able and available to respond. Call 911 if the situation is beyond your ability.

USING ALONE AND RISK OF OVERDOSE

Participants were well aware of the risks associated with using drugs alone, particularly the risk of something going wrong (overdose, injection error) and not having someone available to respond. However, for many participants, the benefits of using alone (such as control over social environment, not having to share drugs) were seen to outweigh the benefits of using drugs with other people. In this scenario, the benefits of using alone were also combined with benefits of using drugs at home (convenience, control/autonomy, and familiarity with physical environment).

Participants shared some of the methods they used to **navigate overdose concerns when using alone**, including:

- Knowing your environment
- Using more predictable products, *"I think when its pills people know how much they can do, when its fentanyl nobody knows, it's different because of what's been going on."*
- Using lower/tester doses *"I try to take it easy because I don't want to die. If I do too much I'm gone, and I'm not even going know if I'm dead or not. I think about that all the time."*
- Letting people know when you are using and having them check in on you.

"Yeah I've overdosed alone at home. What could I do? Nothing. Well somebody had to have found me - I'm still here. I always ask people to come check in on me. I'll say I'm going to go do my thing and if I don't come out within a half hour or so, then come knock on the door."

"Check in on friends - oh yeah people check up on me, or I go check on them"

For many people consulted in this project, the harms that may arise from the immediate consumption of drugs (overdose, injection-related injury) were often eclipsed by other concerns such as stigma, discrimination, exclusion, and oppression.

ENHANCING SAFETY WHEN USING DRUGS OUTDOORS

The most common space where participants reported using drugs was outdoors (27 of 38). Outdoor drug consumption was generally relegated to spaces not already claimed by mainstream economic development interests, including but not limited to; river banks or trails, stairwells, garages, parkades, parks, behind buildings, alleyways, tents, garbage bins, abandoned buildings and houses, train tracks, bus shelters, underground tunnels, in the woods, and rooftops. A number of participants expressed that using outdoors was not necessarily the ideal space; however, it was often used out of necessity.

"I'd go indoors if I could."

However, for others, outdoor use was preferred as it provided several benefits, most notably **convenience.** Participants described that convenience is a central determinant of where they consume drugs. As a result, people who live and work outdoors are more likely to use drugs outdoors.

"I do [use drugs] wherever man, outside even. Yep, I have in the past maybe two months, just outside on the street, back lane, wherever."

Privacy, resources, and safety: Outdoor drug use was described as particularly challenging in terms of navigating tensions between safety features. For instance, while good lighting is an essential resource for injection drug use, well-lit locations also compromise privacy. During the day there are more people around, therefore using during the day would afford less privacy but more light. For some, dusk and dawn provided a favourable balance between lighting and solitude. However, with fewer people around at these times, some shared that it may be easier to be robbed, assaulted, or otherwise victimized.

A foremost concern was that outdoor drug use is highly **susceptible to disruption and harm** from other people. Although disruption and arrest from police were concerns, fear of disruption extended to any people in the vicinity. Being seen by people could result in harms such as discrimination, being judged, yelled at, evicted, jumped, robbed, raped, or otherwise assaulted.

"Well, 'cause the stigma behind it, you know? If they see you using they'll say you're a dirty junkie and blah, blah, blah."

"People, cops, depending on exactly like – you know, if you're under the bridge, if you're by the park, like I say, people walking by, dogs. You know, you don't want a dog running up to you and you've got some dope in your hand and you're trying to cook, and he knocks you over or some shit."

"Well, you got to take your chances, right? Especially when you're on Main Street. You have to keep an eye out for whoever's coming, you know?"

There were different experiences and perceptions among participants regarding patrol organizations (police, BIZ patrol, cadets, Bear Clan, Mama Bear Clan). Some felt that patrol organizations, specifically Bear Clan, contributed to the safety of people who use drugs outdoors. Police were perceived as more threatening if a person has outstanding charges.

In general, due to fear of disruption, participants described that outdoor use was inherently more rushed.

"Wherever I can have a place to hide... a little fix and split."

"If I'm in a place where I feel safe and comfortable I'll stay, but otherwise yes, slam and scram."

And feeling rushed was generally not considered desirable or safe.

"I hate being rushed, I have to go where it's nice and calm"

Further, participants recognized outdoor use as less resourced (lack of access to lighting, clean water, drug preparation surface, sterile injection supplies and needle disposal) making it more difficult to attend to safer drug preparation and consumption techniques.

Participants sought the following features in outdoor drug use spaces:

- **Privacy**
  "I like it to be like kind of hidden actually so nobody sees."
  "Either in the street or the park or anywhere there is a little bit of privacy."
- **Shelter/enclosure** (from dust, wind, dirt, precipitation, and for privacy)
  "A fence or screen of some kind – but more than one entry or exit. As long as it's enclosed"
- **Protection from extreme weather, particularly cold:**
  "I have never been able to do it outside in the wintertime, too cold."
  "I have to warm my hands up before I do it."
  " 'Cause, like I said, when you're outside, your veins, you know, I mean, they're cold, they won't raise up."
  "In the winter I take it inside. Y eah and warmth, especially if it's winter. A heated bus shack."
- **Separation from children or places children congregate**
  "I won't do it if I see kids coming around."
  "Schools and playgrounds, I believe that should be a no-no. I see lots of needles on playgrounds and it really drives me nuts."
- **Good lighting** to assist with drug preparation and consumption
- **Good sight lines and someone to 'keep six' [on the lookout]**
  "Because the aloneness and I put myself in the middle shelf so you always skirt down or go up, because you're in the middle, right? So you'll see the person coming."
- **Egress**
  "I need an exit strategy at all times."
- **Accommodation of other needs** such as electricity to charge a phone, heat vent/output to stay warm, and somewhere with adequate seating.

In other geographical settings, outdoor use has been found to have the least consistent rules because there is often no clear person in charge, and because the people using the space change continually[2].

2. Ouellet, L.J., Jimenez, A.D., Johnson, W.A., & Weibel, W.W. (1991). Shooting galleries and HIV disease: Variations in places of injection illicit drugs. *Crime & Delinquency, 37*(1), 64-85. doi: 10.1177/0011128791037001006

Participants shared that **social norms or rules/ guidelines** of practice were less clear and consistent when using outdoors.

"We make our own rules. Because you want to get high so you're going to do whatever it takes to get high."

However, the most commonly shared guidelines for outdoor use included **keeping drugs away from children, and cleaning up after yourself**. Some participants also expressed avoiding outdoor drug use in or near places of worship or sacred places.

Finally, although participants generally agreed that there should be more **outdoor needle disposal options,** needle drop boxes were not mentioned by participants as a primary feature they looked for in a suitable space to use drugs outside. A pop bottle or other **puncture proof container can be carried to place used sharps in**. Participants described unsafely discarding needles as disrespectful, and several reported picking up after others.

"THE OLDER ONES [PEOPLE WHO USE DRUGS] ARE MORE EXPERIENCED AND THEY HAVE MORE OF A KNOWLEDGEABLE UNDERSTANDING OF USING IN A PRIVATIZED SPACE SUCH AS THEIR OWN HOMES. THE YOUNGER GENERATION THEY DON'T HAVE THAT, AND MOST OF THE YOUNGER GENERATION WHO ARE STUCK IN THIS ATROCITY ARE HOMELESS."

- PARTICIPANT, ON THE SUBJECT OF: LACK OF SOCIAL AND MATERIAL RESOURCES

CONSULTATION WITH SERVICE PROVIDER AND ORGANIZATIONAL REPRESENTATIVES

METHODOLOGY

Interviews were held with formal and informal service providers or other representatives of organizations that work with people who use drugs in Winnipeg. Participants represented various organizations: community health, mental health and addictions, public health, Indigenous organizations, and shelters. The participants worked with organizations that are members of the Safer Consumption Spaces Working Group and were recruited through this working group. One focus group of 6 participants and 5 individual interviews were conducted. In total, 11 people from 7 organizations participated. Whereas the World Cafés held with people who use drugs explored a variety of spaces of drug consumption, the service provider consultation focused specifically on supervised consumption services (SCS).

PERSPECTIVES ON SCS WITHIN SUBSTANCE USE AND HARM REDUCTION SERVICES CONTINUUM

"It's definitely something we need in this city, like, yesterday."

"There are many competing needs for addiction and mental health services in Manitoba at this time. Careful consideration should be made regarding the most effective use of sparse resources in terms of having the biggest impact."

"We don't have a province that is particularly interested in harm reduction or prevention for that matter. And so the challenges would be very [great], and for me it would be, [political]."

Provider participants felt that needs related to drug use and harm reduction in Winnipeg and Manitoba are great. Within an unsupportive political environment for harm reduction approaches, participants discussed the extent to which SCS

would be the best intervention for reducing drug-related harms in Winnipeg. This was a key concern because SCS are expensive to establish and operate compared to other harm reduction interventions. Opening SCS could shift resources away from other harm reduction interventions like safer drug use supply distribution or other substance-related services for Winnipeg and the rest of the province. Provider participants wanted to see public spaces become safer for people to use drugs in, or to simply to be in. Some connected the conversation about SCS to the need to develop managed alcohol programs in the city. Some suggested increased advocacy for a comprehensive multi-pronged approach that includes supervised consumption.

A few participants interrogated whether, instead of SCS, public funds should be used on upstream services like housing.

All of the provider participants shared that SCS was a common topic of conversation among staff at their organizations in staff meetings, trainings, or everyday practice. A third of the participants said they had visited SCS elsewhere, mostly in Vancouver or Toronto, to learn how they work. Some participants believed that there is not enough local evidence to inform the applicability of SCS in Winnipeg, although others felt Winnipeg was similar enough to other places where SCS have been shown to be effective. Some of the provider participants have already been publicly advocating for SCS in Winnipeg and stated their readiness to establish and operate a SCS. Others were interested in supporting or informing the development of SCS if one were to go ahead. Still others were awaiting the results of the consultations with people who use drugs from this project to make any organizational commitments.

PERSPECTIVES ON THE NEED FOR SCS IN WINNIPEG

Provider participants described a local reality that informed why they felt SCS is needed in Winnipeg. Some talked about the recent skyrocketing demand for needles and naloxone kits, or finding more used needles in public spaces. Others discussed the rise in crystal meth use, the emergence of illicit fentanyl, and the increases in preventable overdoses. A few provider participants described rules for people accessing shelters or transitional housing that would deter indoor use (in such spaces), and result in "undignified" outdoor use and/or increased visibility of drug use. In all, changes in the drug market and increased injection drug use (including outdoor use) were among the key evidence that suggested SCS would benefit individuals in Winnipeg. A few provider participants noted that this is not a new problem: people who use drugs have long lacked spaces in which to use drugs that are safe, decriminalized, and wherein their dignity is respected.. One of the provider participants expressed that accessing free needles without "a place to use the needles" was an "incomplete strategy." In order to provide safer spaces, some organizations are establishing "safer washrooms" to increase safety for people who use drugs in public spaces.[3]

"...Even more than the supervised is the decriminalized aspect of it. And I don't think we talk about that enough. We talk a lot about, 'oh you'd have nurses who are there in case you overdose', but nobody really discusses this would actually be a legally safe place for you to use so you wouldn't have to be worrying about the police."

3. **"Safer washrooms"** is a term used to describe public washrooms in which steps have been taken to prevent overdose or other drug-related harms, such as unsafely discarded needles. Safer washrooms are promoted on the assumptions that people *are already* using drugs in public washrooms and that enhancing the safety features of these spaces is a responsibility and ethical imperative.

Provider participants described potential health and social benefits of SCS, which would be contingent upon the ability of the SCS to earn trust from people who use drugs.

HEALTH BENEFITS

Provider participants believed, based on their own experience and on evidence from SCS in other cities, that SCS in Winnipeg would have significant health benefits for people who use drugs. Overdose that occurs at the time of consumption could be reversed by SCS attendants. A few participants cited evidence that other SCS have seen no deaths due to overdose. People who use drugs outdoors were seen to be more likely to experience street violence and provider participants believed that SCS could reduce this violence. The availability of sterile supplies for drug use was seen as important to reduce the transmission of blood borne infections among people who use the SCS. Drug checking[4] was also mentioned as another potential service that could benefit people seeking to use SCS. Staff at SCS could also provide education to clients on safe injection practices, reducing the risk of other injection drug use-related harms such as acute infections. Some believed that SCS should serve people who have used drugs for a long time as they could get connected to needed care (i.e., addiction services), while others felt that newer users, or anyone using drugs would benefit, as SCS provide a safer space for drug use. Interestingly, provider participants did not identify outdoor injection drug use as potentially harmful due to factors such as rushed use; lack of material supplies/clean water, and/or structural violence.

4. Drug checking is a service whereby individuals are able to anonymously submit samples of street drugs to find out if drugs are adulterated with problematic substances.

SOCIAL BENEFITS

Provider participants perceived SCS to provide social benefits by way of creating a dignified space for people to use drugs in. SCS were perceived to decrease the stigma around drug use by providing a socially sanctioned space for drug use. Access to a decriminalized space was a main positive aspect for a few provider participants who believed SCS would prevent arrest or detention for drug use, therefore decreasing the overall involvement of people who use drugs in the criminal justice system. These potential social benefits described by provider participants were distinct from the benefits described by participants in the World Café sessions for people who use drugs; in the World Café sessions, the ability to support belonging, community, and opportunities for gainful employment or volunteering were highlighted as a benefit of SCS.

SERVICE ACCESS

Provider participants described the potential for SCS to both **decrease** and **increase the use of health and social services simultaneously.** If SCS could reduce disease transmission, overdose, and acute infections, clients would need fewer emergency department visits and ambulance services. On the other hand, provider participants felt strongly that having SCS could provide an **entry point** to other services that people who use drugs need but are not receiving due to poor accessibility, mistrust, lack of safety, services that are culturally inappropriate, discrimination, or people not being ready to use those services. Within SCS, onsite primary health care, access to housing, and food security could also be facilitated, as well as detox or addictions treatment, if clients were interested in reducing their substance use.

“WE WOULD ALSO NEED TO BE ABLE TO SPEAK OUT IN SUPPORT OF SUPERVISED CONSUMPTION SITES WITHOUT FEAR OF REPRISAL FROM THE PROVINCE.”

- SERVICE PROVIDER,
ON THE SUBJECT OF: MOVING FORWARD WITH SCS

PERSPECTIVES ON THE CHALLENGES TO IMPLEMENTING SCS IN WINNIPEG

"Depending on the location, uptake among people using substances could be limited."

"SCS do not address individuals who require injection by another person."

Provider participants acknowledged that the majority of people who use drugs likely would not use SCS for a number of reasons. Location is a major consideration. Provider participants expressed that most people will not travel large distances to use SCS. Further, provider participants also noted that Winnipeg's extreme climate limits people's ability and willingness to travel, particularly during the coldest months. In Winnipeg, injection drug use is common in many inner-city neighbourhoods and it was in these areas that provider participants felt it would make the most sense to locate a SCS. However, they also reflected on the implications of this location for people who use drugs outside the inner-city.

In addition, some provider participants noted that people who need someone else to inject them would not use SCS if assisted injection was prohibited (as discussed in the World Café findings). Furthermore, people who have had negative experiences with formal institutions and systems may not trust SCS enough to use it. One of the provider participants suggested that having a known space for drug use may deter people from attending due to fear of being spotted by the police. An arrangement with police would have to be developed and fully communicated to the community of people who use drugs, to the community surrounding the SCS site, and to law enforcement.

PERSPECTIVES ON SCS AND THE PUBLIC

"'Don't put it in my neighbourhood'. So I think that that's still - stigma is a huge issue and barrier for the concept as well."

"... Having the conversations is an opportunity for education with the goal of reducing stigma so that people are not feeling as marginalized, and that we can have bigger conversations around how did we get here and how do we, again, move upstream (...) to prevent people from getting there to begin with."

"We need to know the community is comfortable with this."

A common concern among provider participants was that SCS could increase backlash and stigma from the general public towards people who use drugs, thereby increasing conflict and interference. Provider participants talked about how "not-in-my-backyard-ism" is a serious barrier to new drug-related programs and services. Provider participants suggested that many of these attitudes are based on misinformed views about drug use and harm reduction in general, and of supervised consumption specifically.

On the other hand, provider participants perceived that SCS could potentially benefit the safety of the general public by reducing public injecting and unsafely discarded needles. Dependin on willingness of people to travel to use SCS, both of these benefits would be limited to the specific geographic area around the SCS. In addition, access to SCS could result in significant cost savings to the health and emergency response systems by way of reduced incidences of overdose, and safer injection practices. Many provider participants also saw opening SCS as a valuable opportunity to talk openly with the public about drug use and harm reduction, potentially shifting people's ideas about the root causes of drug use. This dialogue could shift public perception from a narrative that blames individuals for 'choosing' to use drugs

towards one that recognizes the structural and systemic factors, such as colonization and poverty, that create the conditions for problematic drug use.

PERSPECTIVES ON WHAT SCS IN WINNIPEG SHOULD LOOK LIKE

"[Be] strategic about who's staffing it. Right? Because, I think it's beneficial if they're [people who us drugs] able to see themselves reflected when they go into any space."

"What is the right location? How do we maximize impact to individuals and communities?"

Provider participants' insights on providing substance use-related services suggested some key considerations in the design of SCS:

LOCATION AND MODEL

The question of where to locate SCS must be carefully considered. There was a general consensus that SCS should not be located in the suburbs but rather in central Winnipeg where drug-related harms are concentrated. However, because any location will miss some clients due to distance and lack of transportation, provider participants suggested that a multi-site model with locations across the city would more effectively serve more people. Some options would be to integrate SCS into the new Rapid Access to Addictions Medicine (RAAM) clinics or at WRHA Access Centres.

INTEGRATED MODEL

Many provider participants felt it was essential that SCS have health and social services located in the same building (or next door) to improve access to those services. Primary health care and detox/treatment services were the most commonly mentioned services to integrate, followed by testing for sexually transmitted and blood borne infections, and support around housing and food security. A few provider participants gave the example of Onsite, the detox and transitional housing program located in the same building as the Insite Supervised Injection Facility in Vancouver, as a model that Winnipeg could imitate. Provider participants stressed that without additional health and social services in place, SCS would miss unique opportunities to promote wellness among people who use drugs, and who face significant barriers to services. When people are ready to access other services (beyond a consumption space), it is essential to be ready to support them, otherwise trust and interest may be lost. Therefore, adequate resources/services would need to be in place, as well as staff to provide connections to those services.

STAFF AND HOST ORGANIZATION

Other considerations were related to who should staff SCS, with one provider participant suggesting staff should reflect the clients in terms of their identities and experiences. Other provider participants suggested that medically trained personnel should supervise consumption in SCS. A few provider participants noted that it's very important that the organization that runs SCS is trusted by people who use drugs in Winnipeg, and has knowledge and experience in harm reduction approaches, or the service would not be used.

THE SPACE

Although most SCS in other locations have been designed around opiate use, some provider participants believed that SCS in Winnipeg should accommodate people who use different types of substances and routes of consumption. For example, the design of a post-consumption space should have different implications specific to the types of drugs consumed (e.g. opioids versus stimulants). With the widespread use of meth, one provider participant suggested the need for larger post-consumption spaces because of the more physically active high associated with psycho-stimulant use.

MOVING FORWARD WITH SCS

PROVINCIAL APPROVAL[5]

Provider participants expressed that a key barrier to opening up SCS in Winnipeg is the approval of the provincial government. Manitoba's premier and former health minister have expressed that they do not support SCS because there is no evidence to indicate it would work here.[6] Provider participants perceived that in the current provincial political climate, even with evidence, obtaining provincial approval for SCS may not be realistic without engaging in dedicated political advocacy.

"We would also need to be able to speak out in support of SCS without fear of reprisal from the province."

LOCAL EVIDENCE

Provider participants expressed that they wanted more local evidence about whether SCS will work in Winnipeg. Many noted that it is most important to talk to people who use drugs about whether they would use these services, and that their perspectives should drive whether one is created. Based on the number of needles they distribute, one provider participant felt that clients to their services should have access to a SCS within their facilities.

"The lack of evidence is not evidence against it."

"...We need to be making sure that we're engaging people who are impacted by substance use or all sorts of other things that lead to substance use. They're the ones who need to tell us what it is that is needed. And it's up to us - and I mean that in a public service kind of way - to listen."

FUNDING

Provider participants acknowledged that significant funding would be needed to open SCS. Although some organizations who participated in this consultation noted that they are willing to contribute resources toward SCS, additional and adequate funding would be needed for both infrastructure and operations.

"If the government is not supportive of these sites, can staff and the community rely on getting adequate funding?"

PUBLIC UNDERSTANDING AND SUPPORT

As already indicated, societal backlash and stigma could be mitigated, to a degree, by education to the public. Opening SCS could provide an opportunity to do this education through media and public campaigns. However, a lack of public consensus on whether SCS should be opened in Winnipeg should not necessarily prevent interested organizations from moving forward.

"The public would need to be educated about the myths and facts of SCS. I would love to see a public education initiative about this."

COLLABORATION ACROSS SECTORS

Provider participants felt that the health system would need to fund and support the development of SCS. One provider participant indicated that it would also be important to have the support of police and their agreement not to arrest people in the vicinity of SCS.

5. The consultation was conducted in August-September 2018. In the fall of 2018, Health Canada reviewed its approach to supervised consumption facilities. It proposed changes to its approach, including the removal of the forma requirement of a Provincial or Territorial Minister Letter of Support for the SCS application.

6. Keele, J. (2018, December 18) Pallister against safe injection sites for Manitoba. *CTV News Winnipeg*. Retrieved from https://winnipeg.ctvnews.ca/pallister-against-safe-injection-sites-for-manitoba-1.4222955; *Manitoba's health minister rejects idea of a safe drug injection site* [video file]. (2018, April 4) Retrieved from https://www.msn.com/en-us/video/pyeongchang2018/manitobas-health-minister-rejects-idea-of-a-safe-drug-injection-site/vp-AAvtjkZ

"I WOULD SAY ATTACHED [TO A HEALTH SERVICE] JUST BECAUSE IT WOULD BE EASIER TO FIND RESOURCES BECAUSE THEY ARE THERE ALREADY. IT IS NOT LIKE YOU HAVE TO LEAVE, AND THEN GO ALL THE WAY OVER THERE."

- PARTICIPANT, ON THE SUBJECT OF: ACCESS TO HEALTH AND SOCIAL SERVICES

LIMITATIONS

There were significant strengths in this consultation that are evident in the level of engagement from community and depth of information and knowledge shared. There are also some important limitations to acknowledge in our consultation methods and processes related to representation, analysis/interpretation, and resources.

WORLD CAFÉ SESSIONS

As previously stated, participants' needs for safe spaces extended far **beyond places for drug consumption**. This consultation was limited to an exploration of spaces of drug consumption and not equipped to capture the wider needs of those who shared their knowledge and experiences.

Participant data was pulled from group conversations, and did not include a discussion of people's social locations that could be linked to experiences. This approach limited the ability for intersectional analyses. Additionally, this study was not well-equipped to capture the relationships between drug use, activities people like to do when high, and spaces of consumption that may accommodate or constrain these activities (for instance income generating practices, recreation, art, dance, parties, and/or sex).

The participants in the three WC sessions ranged in age from 19 to 71, with an average age of 39 years old. Our recruitment processes did not successfully draw in youth participants, though youth were well-represented at the knowledge translation and member checking session. The spatial practices, needs, and experiences of youth may be distinct from adults due unequal access to resources and limited autonomy over indoor spaces.

Social location differences and power relations between the researchers and participants impact what participants share with a researcher, and how the knowledge is analyzed, interpreted, and reconstructed through a Western worldview. As participants were sharing their knowledge regarding stigmatized and criminalized practices in a group setting, responses are likely to have been shaped by a social desirability bias to some degree and are limited in that accounts were provided by self-report. Furthermore, the WC format involved small group discussions which may have deterred some from participation. Some participants may not have felt comfortable having conversations about highly private and stigmatized practices in a group forum.

Findings are considered partial and temporally specific as the spatial context is dynamic and cannot be adequately captured at a single point

in time. The seasonality of the data collection phase likely impacted recruitment and shaped the knowledge and experience shared. Data was collected from August to September 2018, some of the warmest months of the year when more people are spending time outdoors (average range 12 to 31 Celsius). The winter months of Winnipeg average - 8 to -25 Celsius. Extreme cold has been found to significantly shift outdoor drug use practices and spaces in this setting (Marshall, 2018).

The findings from this study are not intended to be generalized to other populations of people who use drugs; particularly youth (who were not well represented among participants), people from suburban neighbourhoods of Winnipeg, and people in other areas of Manitoba, particularly rural and remote areas where privacy and anonymity is less available. However, some of the principles of safety and harm may be generalizable in other contexts.

The WC session were arranged to explore perceptions and experiences of drug use in four different kinds of spaces: private residences, public washrooms, outdoors, and in SCS. While most of the participants had lived experience using drugs in private residences and outdoors, fewer had experience using drugs in public washrooms, and most had not experienced a SCS. As such, conversation categories did not draw from direct experience of all people – some of the conversations drew up on imagined versus experienced practices – which are distinct forms of knowledge. Further, using drugs in one's own home/private residence arose as a very different experience than using in someone else's home. These topics of "own home" and "private residence of someone else" may have been more effectively explored as separate topics.

Finally, facilitating WC sessions is resource intensive as 5facilitators, 4note takers, room hosts, and food were required for each session. At the same time, recruitment and attendance is difficult to predict, and can result in over and under attendance. Our first session required pre-registration, where participants had to call the researcher to learn the location and confirm attendance, which resulted in approximately 75% attrition from those who pre-registered. When the pre-registration process was removed and invitations were widely distributed, we attained approximately 1 person participating for every 10 invitations distributed. The unpredictability of attendance/participation adds to the resources required as the team needs to be prepared for last minute recruitment and/or managing over-attendance.

SERVICE PROVIDER CONSULTATION LIMITATIONS

All Safer Consumption Spaces Working Group members were invited to participate in a group or individual interviews with an external interviewer. These options were offered to accommodate preference and schedules. Not all organizations participated. Some invitees shared the request for participation to others in their organizations. This resulted in an over-representation of some organizational perspectives, which may have skewed our findings. Similarly, the absence of some organizations may have left some perspectives out of the analysis.

Some providers had toured SCS in other Canadian cities, sharing with confidence what they believed could be translated into the local scene. However, only a few grounded their knowledge on their clients' actual perspectives on supervised consumption.

SUMMARY OF FINDINGS AND LESSONS LEARNED

This study captured perspectives on safety and harms of drug use as they relate to spaces in which drugs are consumed. Implications for supervised consumption services (SCS) in inner-city Winnipeg were shared, as well as implications for enhancing safety in existing places where drugs

"[MY GIRLFRIEND] IS HARD TO HIT SO, ONE TIME SHE SPENT SIX HOURS TRYING TO HIT IT [VEIN]. AND I JUST WATCH HER, UH IT MADE ME SICK, AND SHE'D WANT ME TO RUN GO GET THAT PERSON AND THIS PERSON TO HIT HER."

- PARTICIPANT, ON THE SUBJECT OF: AN SCS INJECTION ASSISTANT

are consumed (public washrooms, outdoors, and in private residences). There were slight differences between the perspectives of people who use drugs and provider participants in terms of safety and harms. While providers tended to focus concerns on the harms of drugs and the way they are consumed, people who use drugs tended to describe the greater burden of harms as arising from the social and institutional environments in which drugs are used. Consequently, the benefits of SCS were perceived slightly differently. Provider participants shared strong ethical commitments to providing services that were meaningful and valued by people who use drugs.

The characteristics of desirable and safe spaces for drug consumption described by participants reflected the principles of harm reduction: pragmatic, non-judgemental, respect for autonomy, privacy, resources, meaningful involvement and inclusion (WRHA, 2016). Some of the desirable spatial characteristics described are key features of SCS (material supplies, access to resources, human support or helpers), while other desirable characteristics such as convenience, privacy, and autonomy, are more challenging for SCS to deliver. Still, many participants who use drugs indicated that they would likely access a SCS.

In this consultation, the participants who use drugs are afforded very little social and material support from the health and social systems that surrounds them, and many accepted this as the norm. This may have influenced the modest nature of the requests for what SCS in Winnipeg may look like. For most participants in the World Café sessions, the spatial needs described included very basic material resources such as needles, needle disposal, a surface on which to prepare drugs, and protection from arrest or assault. Some participants suggested spaces of consumption should contribute to holistic wellness though fostering a sense of belonging, reciprocity, purpose, community, fun, and healing.

"THERE ARE MANY COMPETING NEEDS FOR ADDICTION AND MENTAL HEALTH SERVICES IN MANITOBA AT THIS TIME. CAREFUL CONSIDERATION SHOULD BE MADE REGARDING THE MOST EFFECTIVE USE OF SPARSE RESOURCES IN TERMS OF HAVING THE BIGGEST IMPACT."

- SERVICE PROVIDER, ON THE SUBJECT OF: SCS AND THE PUBLIC

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APPENDIX A: SAFER CONSUMPTION SPACES WORKING GROUP

WORKING GROUP PURPOSE:

The working group is convened on a voluntary and independent basis. Working group members come from Indigenous and non-Indigenous organizations, and includes people who use drugs, and people who inform policies, programs, and practices that impact people who use drugs. The purpose of the working group is to:

1. Inform (and possibly participate in) a service needs assessment of people who use (primarily inject) drugs in Winnipeg, with a focus on interventions that can make spaces in which drugs are consumed safer.
    - This includes but is not limited to the needs and feasibility of supervised consumption services.
2. Inform (and possibly participate in) a needs and feasibility assessment of supervised consumption services from the perspective of formal and informal providers of service and organizational representative that have a role in informing, supporting, exploring, funding, or offering supervised consumption services.
3. Review existing data on local drug use trends and harms.
4. Develop recommendations for safer consumption spaces in Winnipeg based on the findings from the above needs assessment results.
5. Disseminate the results of the needs assessment.

In addition to the process above, the Working Group provides a venue in which to bring together the voices and perspectives of various stakeholders on the topic of spatial interventions including supervised consumption, and combine resources and perspectives for informing a way forward.

Process: Monthly meetings will convene from January 2018 until the needs assessment framework and process is established, undertaken, and analyzed. This is expected to take from 8-18

months depending on the availability of resources to support the project.

DEFINITION OF SUPERVISED CONSUMPTION SERVICES:

Supervised consumption services provide hygienic and decriminalized environments in which people who use drugs can use consume (primarily inject) illegal drugs under the supervision of a health care professional, a trained allied service provider, or a peer (i.e., person who formerly used or currently uses illegal drugs), without the risk of arrest for drug possession.

WORKING GROUP MEMBERS:

The Winnipeg Safer Consumption Spaces Working Group is comprised of various stakeholders or representatives including:

- organizations who have expressed an interest in informing, exploring, or offering supervised consumption services and/or enhancing the safety of existing consumption spaces for people or communities they serve
- organizations who have engaged with media in discussions around SCS
- stakeholders who have expertise from lived experience or work experience of people who may use or benefit from supervised consumption services

MEMBER ORGANIZATIONS INCLUDE:

- WRHA, Population and Public Health, Healthy Sexuality Harm Reduction
- Aboriginal Youth Opportunities (AYO!)
- Manitoba Harm Reduction Network
- Manitoba Area Network of Drug Users: MANDU
- Nine Circles Community Health Centre
- Bear Clan
- Sunshine House
- Manitoba Health, Seniors and Active Living
- Main Street Project
- Downtown Access, WRHA
- Addictions Foundation Manitoba
- Aboriginal Health and Wellness Centre
- Downtown Winnipeg BIZ

ASSUMPTIONS:

The spaces in which drugs are consumed have significant impacts on the benefits and harms of drug use. Currently there are no legally operated SCS in Winnipeg. Private spaces are by far the most commonly used space for drug consumption. Public spaces, including outdoor and indoor spaces (such as public washrooms) are also commonly used for drug consumption. Where supervised/safe consumption services exist, public and private spaces will continue to be used for consumption. Thus, interventions that enhance the safety of all consumption spaces hold the greatest public health potential.

APPENDIX B: PARTICIPANTS' SELF-IDENTIFIED CHARACTERISTICS

SELF-IDENTIFIED CHARACTERISTICS (N=38)		N (%)
WHAT DO YOU IDENTIFY AS YOUR GENDER?	Male	19 (50%)
	Female	16 (42%)
	Non-Binary	1 (2.5%)
	Two Spirit	2 (5%)
HOW WOULD YOU DESCRIBE YOUR SEXUAL ORIENTATION?	Heterosexual	26 (68.5%)
	Gay	4 (10.5%)
	Bisexual	2 (5%)
	Queer	1 (2.5%)
	Asexual or on pause	2 (5%)
	Mixed up	1 (2.5%)
	No answer	2 (5%)
HOW DO YOU DESCRIBE YOUR POPULATION/ETHNIC GROUP?	First Nations (includes Aboriginal, Cree, Ojibway)	16 (42%)
	Métis (includes French Métis, Scottish Métis, Métis/Caucasian)	11 (29%)
	White (includes German, French, Irish)	9 (24%)
	Latin American (includes Mexican/Caucasian)	2 (5%)

CONTINUED...		N (%)
WERE YOU BORN IN CANADA?	Yes	37 (97.5%)
	No	1 (2.5%)
WHAT IS YOUR AGE IN YEARS?	Under 20	1 (2.5%)
	21-30	12 (31.5%)
	31-40	8 (21%)
	41-50	10 (26%)
	Over 50	7 (18.5%)
IN THE LAST MONTH, WHERE HAVE YOU USUALLY STAYED OR SLEPT?	My own place	17 (45%)
	My partner's place	3 (8%)
	A family member's place	3 (8%)
	A friend's place	4 (10.5%)
	Different places all the time	3 (3%)
	Shelter	10 (26%)
	Outside	15 (39.5%)
	Other: Garbage bin, jail, rooftops, transitional housing, sometimes I don't sleep because I have no place	
WHAT NEIGHBOURHOOD DO YOU USUALLY STAY IN?	North End	13 (34%)
	West Broadway	7 (18.5%)
	Downtown Main Street	3 (8%)
	Downtown Central	3 (8%)
	Downtown West End	2 (5%)
	All over core area	2 (5%)
	East Kildonan	3 (8%)
	Elmwood	2 (5%)
	Inkster	1 (2.5%)
	Maples	1 (2.5%)
	St. Boniface	1 (2.5%)
HOW LONG HAVE YOU BEEN IN THAT NEIGHBOURHOOD?	Less than 1 year	9 (24%)
	1-5 years	10 (26%)
	Over 5 years	17 (45%)
WHERE DO YOU USUALLY USE DRUGS?	Outside	27 (71%)
	My own home	17 (45%)
	Public space	16 (42%)
	Someone else's home	14 (37%)
	Vehicle	12 (31.5%)
	Other: everywhere, shelter, wherever, work, school, coffee shop, river bank, back lane, parking lot, away f rom kids, public washroom, out of sight, roof tops.	

APPENDIX C: SUPERVISED CONSUMPTION SERVICES IN CANADA: A SUMMARY OF THE EVIDENCE

SCS are defined as services that provide hygienic and decriminalized environments in which people who use drugs can consume (primarily inject) illegal drugs under the supervision of a health care professional, a trained allied service provider, or a peer (i.e., person who formerly used or currently uses illegal drugs), without the risk of arrest for drug possession.

The impetus for SCS are almost exclusively derived from opioid drug markets, where the harms of drugs are centered around the time of consumption (e.g. immediate overdose fatalities).[1,2] Most evidence focuses on opioid related harms and benefits of SCS. However, newer SCS across Canada are serving greater proportions of people who use psycho-stimulants including crystal meth, indicating that these services are valued by people who use drugs other than opioids. Data from SCS in Edmonton shows that about 30% of community members reported consuming meth.[3,4]

SCS falls under the broader umbrella of harm reduction. Sound evidence shows that SCS allow for safer injection, reduce the transmission of infectious diseases, are associated with lower overdoses, facilitate referrals to treatment and rehabilitation programs, benefit public order, are cost-effective, do not contribute to crime, and do not promote initiation into injection use.[5,1,6-12] Historically, SCS have been established to deal with injection drug-use in broader social and health terms by connecting people with the health care system, including addictions and mental health services; and reducing their social and service isolation.[13,14]

Still, operating policies of government-sanctioned SCS models can impose barriers for some service users by prohibiting common practices such as drug splitting/sharing, assisted injection, or imposing time limits make SCS unacceptable to some.[6,15,16]

The leadership of people who use drugs has greatly shaped SCS and other harm reduction services across Canada.[1]

In response to the opioid crisis, in 2017 the Federal Government lifted some of the requirements for safe injection facilities. With these changes, new models and approaches to SCS are being explored. Across the country proposals for mobile, women's only, hospital-based SCS, and feasibility studies have emerged.1 New SCS have been established in Toronto, Montreal, and Ottawa. More recently sites have been approved in Edmonton, Lethbridge, Calgary, Kamloops, Kelowna, Surrey, Victoria and London.

Overdose Prevention Sites (OPS) have also developed in response to the opioid crisis. OPS are usually run by non-nursing staff in indoor settings where harm reduction supplies are provided, injections are supervised, and Naloxone is administered in case of an overdose.[17,18] These sites have shown promise for unsettling some of the professional power relations that can imbue professional supervised consumption services, and these sites have been able to reach people who would not attend professionally delivered services.[17,18,19] Still, OPS are also gendered and racialized spaces that jeopardized some women's access.[20] Unsanctioned OPS have also been launched (e.g., Toronto, Ottawa) to address a critical need.[21]

As optimal models of SCS are difficult to establish, implementing and evaluating the integration of SCS within a broader spectrum of care may reduce barriers to services for people who use drugs.[14]

On the other hand, SCS could be sites of exclusion, as they become projects of surveillance and discipline that position people who use drugs as "risky" individuals that need monitoring and supervision. From this perspective, SCS may be promoted as a way to purify public spaces and promote public order, and in doing so potentially contribute to or exacerbate social inequities or stigmatizing discourses.[22]

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